**U.S. Department of Justice**
Federal Bureau of Prisons

# Change Notice

**DIRECTIVE BEING CHANGED:** 5310.12
**CHANGE NOTICE NUMBER:** CN-02
**DATE:** March 7, 1995

1. PURPOSE AND SCOPE. This Change Notice defines several new SENTRY "Medical Duty Status" (MDS) Assignments to identify and address the needs of inmates with mental disabilities and includes procedures to use these new MDS categories.

2. SUMMARY OF CHANGES. The Bureau has an ongoing interest in systematically gathering detailed information about disabled inmates to address their needs more effectively. This CN defines three categories of mental disability (i.e., mentally ill, mentally retarded, and learning disabled) and presents a systematic method by which Psychology staff can report occurrences of these mental disabilities and the levels of agency accommodation made to these disabilities.

Specifically, this CN establishes procedures to use that portion of SENTRY's Disability Assignment System dealing with mentally disabled inmates. The Disability Assignment System consists of a series of disability categories which were added to SENTRY's already existing MDS Assignment System to provide a reliable mechanism for gathering and periodically reporting information related to disabilities of inmates.

3. TABLE OF CHANGES

| Remove | Insert |
|---|---|
| Chapter 2, Page 11 | Chapter 2, Pages 11-15 |

4. ACTION. File this Change Notice in front of P.S. 5310.12, the Psychology Services Manual.

\s\
Kathleen M. Hawk
Director

**U.S. Department of Justice**
Federal Bureau of Prisons

# Change Notice

**DIRECTIVE BEING CHANGED:** 5310.12
**CHANGE NOTICE NUMBER:** CN-01
**DATE:** August 31, 1994

1. PURPOSE AND SCOPE. This Change Notice revises the Psychology Services Manual, Chapter 5, on Special Inmate Programs.

2. SUMMARY OF CHANGES. This Change Notice adds the Living Free Program to the Psychology Services Manual. The Living Free Program is designed to assist inmates to develop a more socially acceptable lifestyle through a review of their values.

3. TABLE OF CHANGES

| Remove | Insert |
|---|---|
| Chapter 5, Page 7 | Chapter 5, Pages 7 - 9 |

Changes are indicated by an asterisk (*) before and after new information.

4. ACTION. File this Change Notice in front of Program Statement 5310.12, Psychology Services Manual.

\s\
Kathleen M. Hawk
Director

**U.S. Department of Justice**
Federal Bureau of Prisons

# Program Statement

**OPI:** CPD
**NUMBER:** 5310.12
**DATE:** August 30, 1993
**SUBJECT:** Psychology Services Manual

1. PURPOSE AND SCOPE. To establish operational policy, procedures, and guidelines for the delivery of psychological services within the Bureau of Prisons. The Psychology Services Manual is a concise, yet comprehensive set of operational guidelines for the practicing psychologist in the Bureau of Prisons. It is designed to serve as a training device for psychologists new to the Bureau as well as a ready reference for more experienced Bureau psychologists. This Manual is periodically updated to reflect the rapidly changing nature of professional psychology within a correctional setting.

2. DIRECTIVES AFFECTED

a. Directive Rescinded

P.S. 5310.8 Psychology Services Manual (09/16/87)

b. Directives Referenced

P.S. 1070.02 Research (09/25/81)
P.S. 1210.10 Management Control and Program Review Manual (12/23/91)
P.S. 1232.03 Personal Computers (06/15/90)
P.S. 1237.07 Computer Security (06/15/93)
P.S. 1351.02 Privacy Act of 1974 (09/25/75)
P.S. 1351.03 Automated/Personal Record Data Security (05/17/88)
P.S. 1353.01 Release of Records (05/29/75)
P.S. 1353.02 Record of Information Release Form BP-171 (12/11/75)
P.S. 2100.01 Budget Manual (03/01/66)
P.S. 3000.01 Personnel Manual (10/01/84)
P.S. 3420.06 Bureau of Prisons Standards of Conduct and Responsibility (01/05/91)
P.S. 3792.03 Employee Assistance Program (EAP) (01/08/88)
P.S. 3932.02 Correctional Counselor Training and Reference Guide (04/12/93)
P.S. 5070.07 Study and Observation Report (08/12/92)
P.S. 5270.07 Inmate Discipline and Special Housing Units (12/29/87)
P.S. 5290.07 Intake Screening (07/20/92)

P.S. 5290.08 Admission and Orientation Program (04/20/93)

| | |
|---|---|
| P.S. 5310.11 | Witness Security Evaluation Program (10/09/92) |
| P.S. 5321.04 | Unit Management Manual (02/14/90) |
| P.S. 5324.01 | Suicide Prevention Program (04/24/90) |
| P.S. 5566.03 | Use of Force and Application of Restraints on Inmates (05/15/89) |
| P.S. 5557.05 | Hostage Situation Management (12/11/91) |
| P.S. 6000.03 | Health Services Manual (03/15/90) |
| P.S. 6190.01 | Human Immunodeficiency Virus (HIV) Programs (01/22/91) |
| P.S. 7331.02 | Pre-Trial Inmates (11/10/80) |

Federal Personnel Manual
Title 5, U.S. Code, Section 552 and 552a
Title 18, U.S. Code, Section 4241-4247
Federal Rules of Criminal Procedures, Rule 12.2

3. STANDARDS REFERENCED

a. American Correctional Association Foundation/Core Standards for Adult Correctional Institutions: FC2-4012, FC2-4013, FC2-4042, FC2-4070, FC2-4071, FC2-4074, FC2-4075, FC2-4078, FC2-4079, FC2-4089, FC2-4098, C2-4040, C2-4047, C2-4054, C2-4110, C2-4112, C2-4113, C2-4138, C2-4139, C2-4140, C2-4141, C2-4142, C2-4144, C2-4146, C2-4147, C2-4148, C2-4151, C2-4154, C2-4158, C2-4161, C2-4164, C2-4209, C2-4221, C2-4247, and C2-4248;

b. American Correctional Association 3rd Edition Standards for Adult Correctional Institutions: 3-4069, 3-4082, 3-4105, 3-4109, 3-4110, 3-4244, 3-4245, 3-4246, 3-4261, 3-4272, 3-4273, 3-4284, 3-4292, 4-4326, 3-4327, 3-4334, 3-4336, 3-4337, 3-4338, 3-4339, 3-4340, 3-4342, 3-4344, 3-4345, 3-4349, 3-4355, 3-4364, 3-4366, 3-4367, 3-4368, 3-4369, 3-4371, 3-4372, 3-4377, 3-4380, 3-4381, 3-4382, 3-4383, 3-4384, 3-4386, 3-4387, 3-4388;

c. American Correctional Association Foundation/Core Standards for Adult Local Detention Facilities: FC2-5075, FC2-5076, FC2-5079, FC2-5082, FC2-5083, FC2-5085, FC2-5088, FC2-5095, FC2-5097, C2-5062, C2-5082, C2-5083, C2-5156, C2-5178, C2-5180, C2-5181, C2-5182, C2-5183, C2-5192, C2-5255, C2-5258;

d. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF-1C-25, 1F-09, 1F-10, 1F-11, 3D-08, 3D-24, 4A-01, 4B-03, 4E-01, 4E-02, 4E-09, 4E-11, 4E-12, 4E-13, 4E-15, 4E-16, 4E-18, 4E-19, 4E-20, 4E-21, 4E-36, 4E-37, 4E-38, 4E-40, 4E-41, 4E-42, 4E-43, 4E-47, 4F-01, 4F-02, 4F-03, 4F-04, 4F-05.

e. American Psychological Association Ethical Principles of Psychologists and Code of Conduct (1992).

f. American Psychological Association General Guidelines for Providers of Psychological Services (1987).

g. American Psychological Association Specialty Guidelines for Providers of Psychological Services (1987).

h. American Psychological Association Standards for Educational and Psychological Testing (1985).

i. Specialty Guidelines for Forensic Psychologists, Division 41, American Psychological Association and the American Psychology-Law Society (1991).

4. DISTRIBUTION. A copy of this Manual is to be distributed to each Bureau Psychologist. Two copies of this Manual will also be sent to each institution, regional office and training center. All employees shall have access to any and all information contained in this Manual and may have copies of any portions of it.

5. ACTION. The delivery of psychological services in all Bureau of Prisons facilities shall be in accordance with the guidelines set forth in this Manual.

Kathleen M. Hawk
Director

# TABLE OF CONTENTS

## SECTION B - INMATE SERVICES

### Chapter 3 Treatment of the Mentally Ill Inmate



### Chapter 4 Routine Mental Health Services

**Chapter 5 Special Inmate Programs**



**SECTION C - STAFF SERVICES**

**Chapter 6 Psychology Programs for Bureau Staff**



**Chapter 7 Psychology Predoctoral Internship, Postdoctoral Residency, and Continuing Education Programs**

## SECTION D - CLINICAL/CONSULTATION SERVICES

### Chapter 8 Special Clinical/Consultation Programs



### Chapter 9 Psychology Evaluation Programs

## LIST OF ATTACHMENTS

SECTION A

# ADMINISTRATION AND MANAGEMENT OF PSYCHOLOGY SERVICES

# CHAPTER 1

# ORGANIZATION OF PSYCHOLOGY SERVICES

# CHAPTER 1

# ORGANIZATION OF PSYCHOLOGY SERVICES

## 1.1 PSYCHOLOGY SERVICES MISSION STATEMENT

The primary mission of Psychology Services within the Bureau of Prisons is to provide appropriate psychological, psycho-educational, and consultative services to inmates and staff.

Psychological services within each institution should be sufficient to ensure that every inmate with a documented need and/or interest in psychological treatment has access to a level of care comparable to that available in the community and consistent with the overall mission of the institution. The Psychology Services Department of each institution should present an overview of the programs available to all inmates through the Admissions and Orientation Program.

The Psychology Services Department at each institution may also offer consultative services, periodic psychoeducational training opportunities, and community mental health referral services (as needed) to institution staff. These services should be explained to new employees during Institution Familiarization Training and to all staff during Annual Refresher Training.

## 1.2 MODEL OF SERVICE DELIVERY

By serving in the role of a practitioner/consultant within the Correctional Programs Division of the Bureau of Prisons, psychologists are afforded a unique opportunity to apply behavioral science principles to the many complex problems and issues facing correctional workers today. Attachment 1-A presents the Bureau of Prison's Psychology Services Program Model. Based on this model, Bureau psychologists offer services in three broad program areas: inmate services and programs; staff services and programs; and clinical/consultation services and programs. To most efficiently and effectively deliver these psychological services (many of which are confidential in nature), the Psychology Services Department should be organized as a separate, centralized department within the institution with adequate space and resources to meet the psychological treatment, program, and consultation needs of the institution.

### A. INMATE SERVICES AND PROGRAMS

Through the application of sound behavioral science practices, it is hoped that Bureau psychologists can assist in creating a safe, humane environment where inmates can develop habits and skills which will make them more productive members of society following their release from prison. At a minimum, Bureau psychologists are expected to conduct psychological assessments of inmates new to the institution and to address their assessed needs through crisis intervention services and

other therapeutic approaches.

Bureau psychologists are instrumental in delivering a variety of diagnostic and treatment programs in such areas as: crisis counseling, drug abuse treatment, candidate evaluations for the Government's Witness Protection Program, suicide prevention, sex offender treatment, and AIDS counseling. In addition to offering a wide range of individual and group treatment programs, Bureau psychologists are also instrumental in screening, treating, and monitoring severely disturbed inmates at the institutional level or in referring these inmates to one of the Bureau's medical/psychiatric treatment centers if they require more intensive inpatient care.

**B. STAFF SERVICES AND PROGRAMS**

The Bureau of Prisons expects its psychologists to apply their specialized knowledge and expertise not only to the mental health needs of inmates, but also to the unique problems facing correctional workers. Psychologists are typically involved in a number of institutional activities aimed at enhancing the knowledge, professionalism, and mental well-being of staff. For example, psychologists provide diagnostic and referral services to staff experiencing mental health problems through the Employee Assistance Program. They also are involved, through the pre-employment interview process, in the selection of new staff, and offer training programs for staff on a variety of mental health topics relevant to corrections.

**C. CLINICAL/CONSULTATION PROGRAMS AND SERVICES**

Bureau of Prisons psychologists serve as organizational consultants by bringing their expertise in the behavioral sciences to bear on correctional issues facing the agency. Psychologists make contributions in such organizational areas as inmate classification; staff recruitment, development, and retention; preventive mental health programming; Hostage Negotiation; and Family and Employee Services during and after critical incidents. Bureau psychologists can be expected to continue contributing their expertise in the future as new issues emerge within the field of corrections.

## 1.3 ORGANIZATIONAL STRUCTURE OF PSYCHOLOGY SERVICES

The Bureau of Prisons' organizational chart for Psychology Services is presented in Attachment 1-B. Psychology Services is represented and offers services at the Central Office level, Regional Office level, and Institutional level.

## 1.4 PRIORITIES FOR THE DELIVERY OF PSYCHOLOGICAL SERVICES

The following description of the professional duties, priorities, and responsibilities of Bureau psychologists is presented as a general guide. Service delivery priorities within any specific institution may vary depending upon the institution's mission, security level, staff and inmate characteristics, and the availability of resources. Consequently, the institution's Chief Psychologist is responsible for designing a psychological service delivery system that gives consideration to the unique nature of an institution as well as the treatment needs of the inmate population.

### A. PRIORITY N0. 1

- Acute crisis intervention (e.g., suicidal, dangerous, or psychotic inmates)
- Suicide Prevention Program
- Treatment of mentally ill inmates
- Employee Assistance Program (crisis intervention with staff)
- Court ordered evaluations and reports
- Special psychological reports (Parole Commission, DHO, hospital referrals, Witness Protection evaluations, etc.).
- Initial psychological screening evaluation of newly admitted inmates
- Detention/Segregation Unit visits and periodic psychological reports
- Assuring compliance with professional, correctional, and other applicable standards

### B. PRIORITY NO. 2

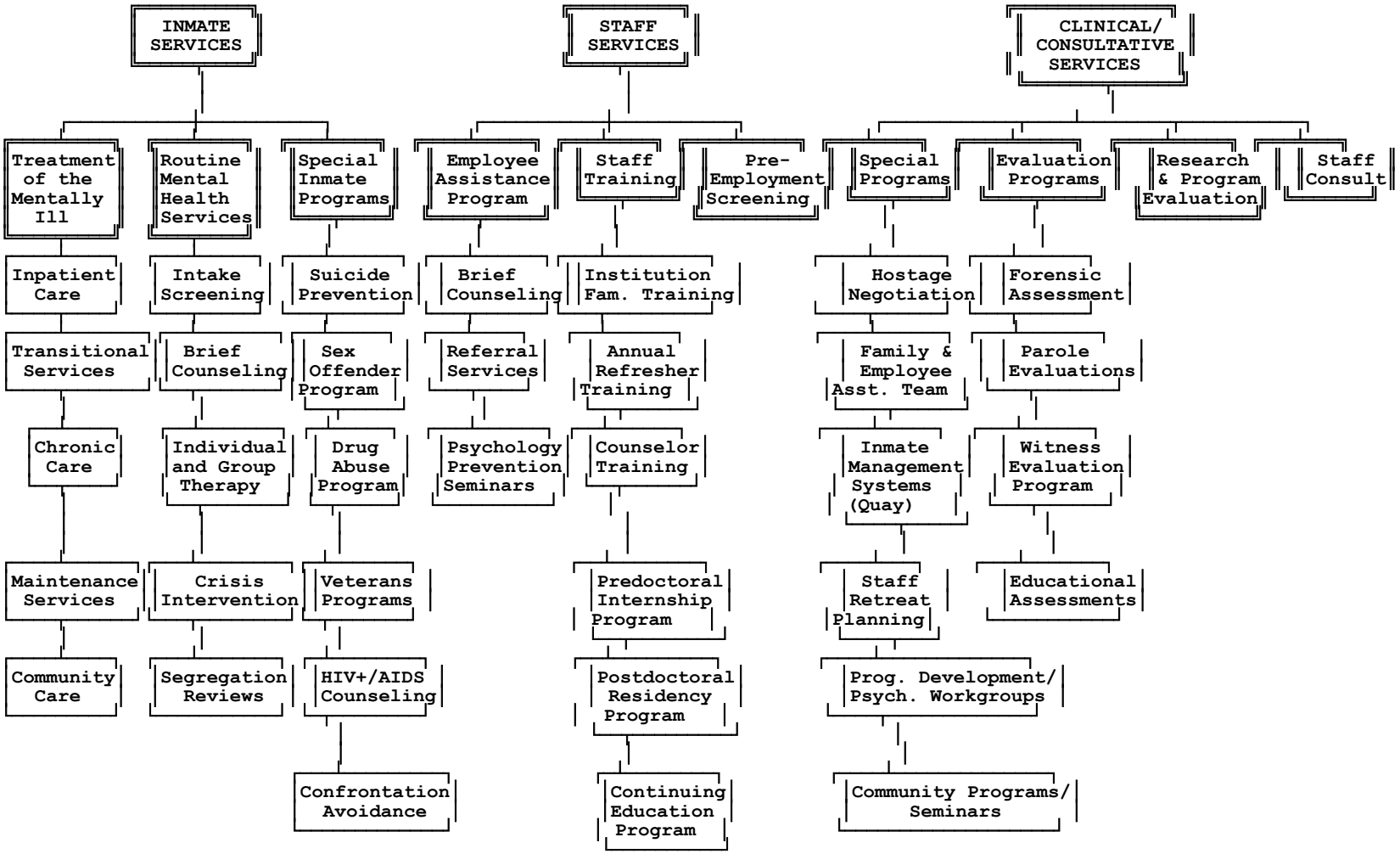
- Brief counseling activities
- Individual psychotherapy or psychoeducational/therapeutic group programs with treatment plan
- Maintenance of treatment notes in psychology file

- Staff training in psychological areas
- Personnel interviews for all new Bureau applicants
- Attending institutional meetings (i.e., budget, training, EEO, Lieutenants., Warden, Associate Warden, (Programs), etc.)
- Special treatment programs (e.g., drug abuse program)
- Maintenance of psychological entries into medical and central files
- Recruitment of psychologists and psychology interns and residents

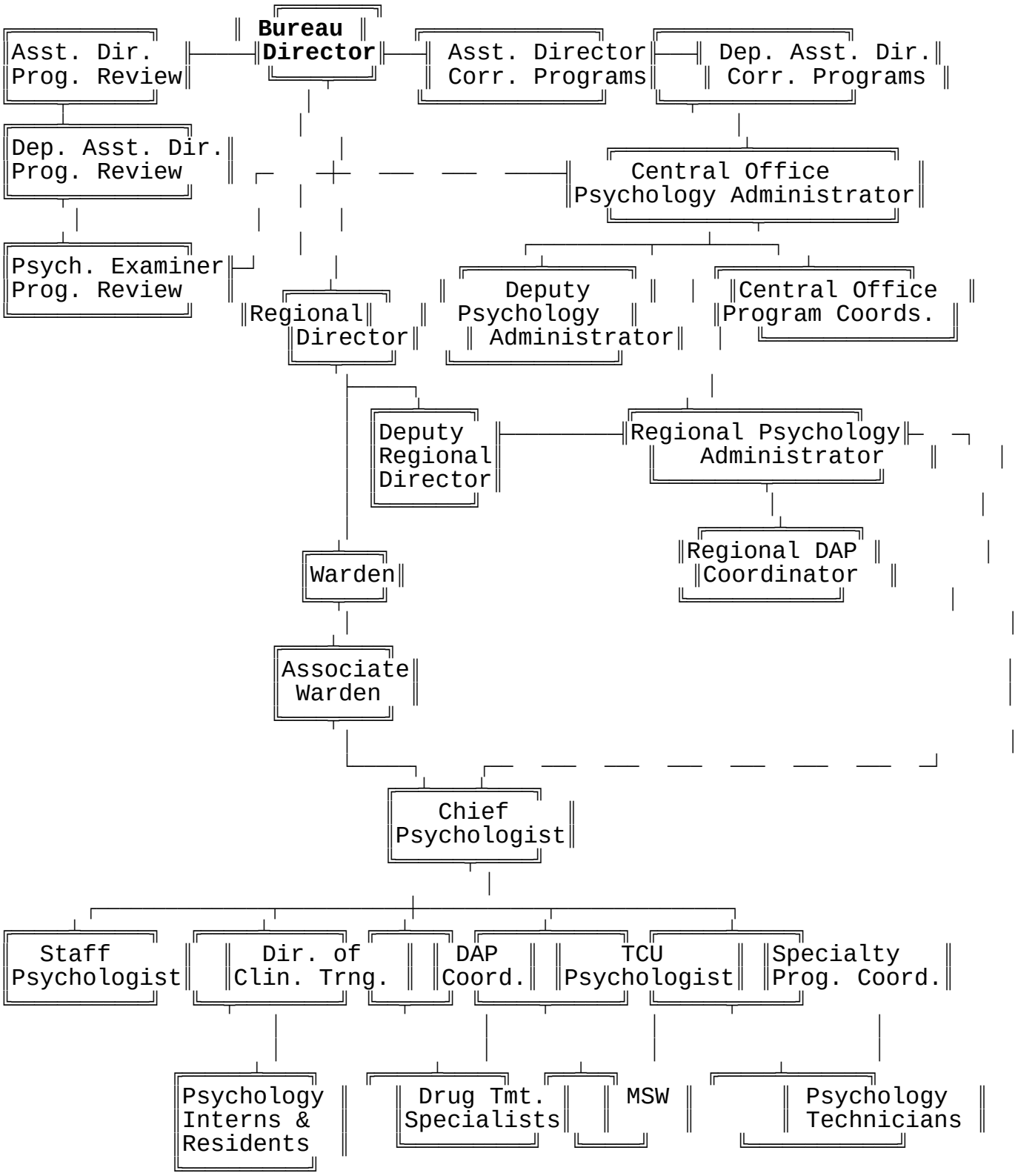
**C. PRIORITY NO. 3**

- Program consultation for UDC and DHO
- Unit/team consultation regarding inmate classification and program review
- Consulting with other institutional departments
- Institutional program development, program evaluation, and research projects
- Participation in seminars, conferences, and community programs

# PSYCHOLOGY SERVICES PROGRAM MODEL



**ORGANIZATIONAL CHART**
Psychology Services



# CHAPTER 2

# PROFESSIONAL, ETHICAL, AND LEGAL ISSUES AND STANDARDS

## 2.1 PROFESSIONAL STANDARDS OF CONDUCT

The following professional standards govern the conduct of psychologists employed by the Bureau of Prisons. They define what is considered an acceptable level of professional behavior across a wide range of professional issues. As such, they may be used to help gauge the standard of care required by providers of psychological services.

A. **Ethical Principles of Psychologists and Code of Conduct**, American Psychological Association, 1992.

B. **General Guidelines for Providers of Psychological Services**, American Psychological Association, 1987.

C. **Specialty Guidelines for Providers of Psychological Services**, American Psychological Association, 1987.

D. **Standards for Educational and Psychological Testing**, American Psychological Association, 1985.

E. **Specialty Guidelines for Forensic Psychologists**, Division 41, American Psychological Association and the American Psychology-Law Society, 1991.

F. **Standards of Employee Conduct and Responsibility**, Federal Bureau of Prisons, P.S. 3420.06 dated 01/05/91.

G. American Correctional Association's Commission on Accreditation for Corrections Standards:

   (1) **Foundation/Core Standards for Adult Correctional Institutions**, April, 1989;

   (2) **3rd. Edition Standards for Adult Correctional Institutions**, January, 1990;

   (3) **Foundation/Core Standards for Adult Local Detention Facilities**, January, 1989;

   (4) **3rd. Edition Standards for Adult Local Detention Facilities**, March, 1991; and

   (5) **ACA 1992 Standards Supplement**, February, 1992.

When a psychologist is functioning outside the strictly defined parameters of his or her professional role, the practitioner's actions are governed by Bureau of Prisons' Program Statements and Operations Memoranda.

## 2.2 PRIVACY AND CONFIDENTIALITY

Issues of privacy and confidentiality regarding the delivery of psychological services to inmates are governed by federal statute (i.e., Title 5, U.S. Code, Sections 552 and 552a), state laws, and by APA's Ethical Principles of Psychologists and Code of Conduct.

### A. MAINTAINING AND DISCLOSING PSYCHOLOGY RECORDS

Psychology records are defined as all information contained in the individual's Psychology File (either in hard copy or in the computerized Psychology Data System). These records typically include such items as the intake screening summary report and inmate questionnaire, Administrative Detention/ Disciplinary Segregation Reviews, psychological reports, chronological records of contacts, raw test data, treatment plans, therapy notes, etc.

APA's Ethical Principles of Psychologists and Code of Conduct indicates that psychologists maintain, disclose, and dispose of psychological records in accordance with relevant law and standards defined within this APA document. Relevant federal law governing record keeping practices within the Bureau of Prisons includes the Privacy Act of 1974 (Title 5, U.S. Code, Section 552a) and the Freedom of Information Act of 1974 (Title 5, U.S. Code, Section 552).

Psychology files, like Central, Medical, and Education files, are considered official agency records which are owned and managed by the Bureau of Prisons. Psychologists are considered managers and contributors to these records during the inmates period of confinement. As such, the provisions of both the Privacy Act of 1974 and the Freedom of Information Act of 1974 apply to the management of information contained within the Psychology File.

The intention of these Acts is to safeguard the individual against invasion of personal privacy. The Privacy Act of 1974 allows for the release of Public Record Information (see Attachment 2-A), but generally forbids (with some exceptions) the release of all other information from agency records without a written request by, or prior written consent of, the individual to whom the record pertains.

(1) Even after the individual's consent has been obtained for release of information, the psychologist should clearly identify such information as confidential to the recipient of the information. Attachment 2-C contains a sample "Release of Information" form.

(2) Specific circumstances where release of psychology records is allowed under the provisions of the Privacy Act of 1974 are presented in Attachment 2-B. Psychologists who have any question regarding the release of a specific document from the Psychology File in a given incident are encouraged to consult their Regional Psychology Administrator and/or Regional Counsel for clarification.

(3) When Psychology records are released, the signed release form documenting what information was released and to whom the information was released should be maintained in the Psychology file. When Psychology file information is disclosed orally, a written memorandum should be placed in the file. This memorandum should include what information was released, when the information was released, and who received the information.

(4) When psychological test protocols and notes related to the individual's test taking behaviors are released, this information should only be released to a person recognized by the psychologist as competent to use the data. Exceptions to this rule should only be made as a result of a court order.

(5) While the Privacy Act of 1974 generally permits an individual access to his medical (psychological) record, it also exempts certain records from this access. Included in this exemption are records compiled during the enforcement of criminal laws, and as such, BOP treatment records on inmates fall into this exemption. However, all psychological records, reports, memos, case notes, etc., should be written with the assumption that the material may be disclosed at some future point to the inmate, courts, attorneys, etc., unless the writer can clearly support the argument that releasing the information will cause "actual harm" to the subject of the document, the preparer of the document, or other specific individuals named in the document. In short, except under extreme circumstances, documents should be written with the assumption that they will be disclosed to the subject or other interested parties.

Civil sanctions and criminal penalties can be imposed on persons who violate these Acts. For a more detailed description of these Acts and their impact on Bureau records, the following Bureau Program Statements are referenced: Privacy Act of 1974; Automated/Personal Record Data Security; Release of Records; and Record of Information Release.

## B. INMATE/THERAPIST RELATIONSHIP

Except for Rule 12.2, Federal Rules of Criminal Procedure, which deals with the relationship between a psychological examiner and defendant in cases defined by Title 18, U.S. Code, Sections 4241 and 4242, there are no federal statutes specifically defining any privileged relationship between an inmate and his or her therapist. In the past, federal courts have looked to common law and state statutes to define the degree of confidentiality inherent in the therapist/patient relationship. Some states have no law defining therapist/patient relationship. Other states do have laws defining this relationship, although they differ somewhat in terms of degree of privilege or who "owns" the privilege. Therefore, psychologists are encouraged to consult with their State Psychological Association, their Regional Psychologist, and their Regional Counsel to determine the exact degree of confidentiality allowed by law in the state in which they offer therapeutic services.

Psychologists should also be guided in their actions by APA's Ethical Principles of Psychologists and Code of Conduct. Based on this document, confidential information obtained from a therapeutic relationship should not be disclosed without the consent of the individual unless mandated by law. Typically laws will mandate that confidential information be released without the individual's consent in order to protect the individual or others from harm or in cases where child abuse is suspected.

## C. DISCUSSING THE LIMITS OF CONFIDENTIALITY

Inmate users of psychological services within the Bureau of Prisons should be informed in advance of any limits to the confidentiality of their contact with psychology staff, (e.g., that the court will receive a report, that there is a duty to warn in certain instances, that information may be shared on occasion with other BOP staff, that psychology records are accessible under specific circumstances, that specific psychological information has been requested by a referring agency, supervisor, or staff member, etc.).

Since psychology staff work for many "clients" within the Bureau of Prisons (i.e., the Courts, the Parole Commission, Wardens and other administrative staff, institution staff, and inmates), clearly defining who the client is to all involved parties represents the best "rule of thumb" when providing psychological services within the correctional environment.

## 2.3 DUTY TO WARN

General guidelines setting forth the conditions necessary for a therapist's duty to warn were established based upon the landmark decision in Tarasoff v. Regents of the University of California (1968). The duty, as defined by the court in the Tarasoff case, arises when a therapist determines that a client presents a serious danger of violence to another. When such a determination is made, the therapist is obligated to use reasonable care to protect the intended victim against such danger. Subsequent court decisions in other states have rendered slightly differing opinions on the psychologist's duty to warn.

Title 18, U.S. Code, Sections 4243 and 4246 specify that mental health professionals have a duty to recommend hospitalization, through the federal court system, when an individual, because of mental illness, presents a substantial risk of bodily harm to another person or serious damage to the property of another. The Bureau's Health Services Manual defines "substantial risk" as a belief by treatment staff that the inmate will, if released, commit a violent act within six months.

Federal courts have also deferred to the substantive laws of the state in which the psychologist practices to help define duty to warn issues, especially in cases where mental illness is not clearly involved. Therefore, Bureau Psychologists are advised to contact relevant state agencies such as their State Psychological Association and to consult with their Regional Psychologist and Regional Counsel in order to determine how duty to warn issues are interpreted within their state.

The APA's Ethical Principles of Psychologists and Code of Conduct also permits the communication of information obtained in a therapy setting when there is clear and imminent danger to an individual or to society.

In beginning a therapeutic relationship with an inmate, it is mandatory that psychologists clearly establish that this duty to warn exists and place a limitation on the confidentiality of information shared in therapy which threatens another.

## 2.4 PROFESSIONAL ETHICS AND ROLE CONFLICTS

APA's Ethical Principles of Psychologists and Code of Conduct states that psychologists should avoid exploiting the trust and dependency of clients and should make every effort to avoid dual relationships with clients that could impair their professional judgement or increase the risk of client exploitation.

Ethical issues have, on occasion, surfaced, creating difficulty for psychologists asked to function in roles which they view as representing a dual relationship. Typically, conflicts arise when psychologists feel that the role they are being asked to perform jeopardizes their professional integrity, and thereby, hinders their effectiveness in delivering subsequent services.

These "dual role" issues are significant in that they can be viewed as a violation of the APA's Ethical Principles of Psychologists and Code of Conduct and can place the psychologist in a difficult position. If the psychologist willingly assumes these roles and violates this Ethical Standard, the psychologist runs the risk of possible exclusion from the American Psychological Association and loss of professional license from State Boards of Examiners of Psychologists. If the psychologist refuses to assume these roles, the psychologist runs the risk of Bureau disciplinary action and gives the appearance of not being a good "team player".

In order to avoid problems in this potentially sensitive area, the following general rules should be adhered to:

A. Inmates should be advised of the nature of the relationship which exists between the psychologist as an employee of the BOP and as a provider of psychological services to the inmate. Issues related to the confidentiality of private information shared within a therapy setting and the handling of psychological records should be explained to inmates prior to receiving services.

B. At times psychologists will be asked to assume duties like Acting Associate Warden, Institution Duty Officer, or Administrative Duty Officer which are outside the range of their routine clinical or Psychology Department responsibilities. All psychologists are encouraged to engage in these types of activities as part of their contribution to the institution and for their own personal development. If, while serving in one of these positions, they have to make a decision about an inmate who is a therapy client, the psychologist should excuse himself or herself from making that specific decision.

C. When asked to provide coverage during non-emergency situations such as Annual Training, psychologists should only be assigned to duties consistent with their professional capacity and in conformance with standards established by the APA and guidelines set forth in this Manual. If this is not possible, psychologists should be assigned duties similar to other professional staff within the institution such as physicians, dentists, attorneys, etc.

D. It should be clear that the above discussion pertains only to non-emergency situations. In emergency situations psychologists are expected to assume duties wherever needed and assigned.

E. Should a problem arise in this area, the psychologist is encouraged to consult with his or her Regional Psychologist for guidance in how best to resolve the issue.

## 2.5 TREATMENT RIGHTS

The right to treatment and the right to refuse treatment has received considerable attention over the years from the Courts. When inmates are committed under statutes which mandate treatment (e.g., Title 18 U.S. Code, Chapter 313, Sections 4241-4247, Offenders With Mental Disease or Defect) or become mentally ill during incarceration, there is an obligation on the part of the psychology staff to provide these individuals appropriate psychological treatment. These efforts should be documented, as should the inmate's response to the services offered.

Regularly committed inmates should also have access to appropriate treatment opportunities. However, an inmate can refuse to participate in psychological treatment unless adjudicated under Title 18, U.S. Code, Chapter 313, or other Court-ordered treatment. The necessary condition for involuntary treatment is whether the inmate is an immediate danger to himself or others or is likely to cause serious property destruction. In each case, the competence of an individual inmate to make his or her own treatment decisions should be carefully evaluated and documented. All regularly committed mentally ill inmates unable to function in a regular correctional environment and needing intensive, inpatient, psychological/psychiatric care are to be referred to one of the Bureau's Diagnostic and Observation Units which are located at each of the Bureau's Medical Centers (refer to Chapter 3 of this Manual and/or the Health Services Manual for more detailed information).

Typically, seriously disturbed pretrial detainees receive treatment (short of forced medication) at their MDC/MCC. In very critical cases, every attempt is made to get the Court to issue an order committing the detainee under Title 18, U.S. Code, Chapter 313 to one of the Bureau's Medical Centers.

## 2.6 PSYCHOLOGY DATA SYSTEM (PDS)

The documentation of Psychology Services activities and reports is computer automated through the Psychology Data System (PDS). PDS's computer software package tracks all professional services delivered to inmates on a monthly basis. Each Psychology Department is required to use PDS to document professional contacts and create periodic reports of these activities. This documentation serves as the basis of professional communication among colleagues and provides data for institutional, regional, and national statistical reports.

Data generated through the Drug Abuse Program is also recorded on PDS. These data include results of psychological test instruments administered and a detailed tracking system for recording total program participation.

The documentation of psychological services to inmates confined as either medical or psychiatric inpatients in any of the Bureau's Medical Centers does not occur on PDS. Rather, this information is entered into the inmate's medical "patient chart" consistent with JCAHO standards and becomes a part of the inmate's overall interdisciplinary treatment record.

### A. PROFESSIONAL SERVICES DOCUMENTATION

PDS allows for the professional documentation of the following services to inmates: intake screenings, treatment plans, detention reviews, suicide referral and watch summaries, evaluation reports, memoranda, and other professional contacts such as crisis intervention, individual therapy notes, and brief counseling comments. Psychotherapy and psychoeducational group data including inmate attendance, participation, completion of homework assignments, and number of group hours completed should also be recorded on PDS. Each professional service area noted above not only provides information on a specific inmate, but also for the total institution population.

Limited biographical information on new inmates, extracted from SENTRY, is provided to each institution on a monthly basis by the PDS Coordinator who is located at the MSTC, Aurora, Colorado. Psychology staff should update their local PDS database through the automated process included in PDS when they receive this monthly SENTRY information from the PDS Coordinator.

## B. MONTHLY PSYCHOLOGY AND DRUG TREATMENT ACTIVITIES REPORT

The monthly Psychology and Drug Treatment Activities Report is generated by PDS and is divided into two sections - one for reporting administrative activities and the other for reporting professional services delivered during the month. Professional services are automatically tabulated by PDS based on entries made throughout the month. Administrative activities must be tabulated manually and entered onto this reporting form at the end of each month.

The completed Psychology and Drug Treatment Activities Report for the preceding month's activities should be forwarded via the monthly PDS downloading process to the PDS Coordinator by the fifth working day of each month. Whenever PDS data is transferred through the U. S. Postal Service, certified or registered mail should be used. Prompt reporting to the PDS Coordinator provides for up-to-date national, regional, and institutional statistics which can be used for general informational and planning purposes.

## C. REPOSITORY OF TOTAL PROFESSIONAL INFORMATION

The total sum of all professional information entered into PDS from all BOP Psychology Services and Drug Treatment Programs is maintained by the PDS Coordinator. Professional contacts and reports entered into PDS on all inmates are archived and maintained by the PDS Coordinator. These archives provide a "backup" for all institution data and serve as a reference for BOP psychological information and statistics.

## D. PDS SOFTWARE

The PDS software package is easily installed and can be run on any IBM or "IBM Compatible" personal computer with a minimum of 640K of RAM and DOS 3.3 or higher. The package runs on a stand-alone computer or local area network.

Some Psychology Departments have computer systems which are connected through a local area network and others have one or more stand-alone computers. For the stand-alone computers, PDS provides a procedure for centralizing all institution data onto one computer to facilitate the collection of monthly statistical data.

Updated versions of PDS are distributed to all institutions as software changes occur as a result of modifications in institutional, Regional, or Central Office data needs. PDS updates will come with an installation program to minimize installation errors.

The PDS Technical Manual (which can be obtained from the PDS Coordinator) explains all PDS operations, procedures, and printouts. User information is periodically provided in conjunction with new SENTRY Extract data, updated software versions, or via SENTRY message. The PDS Coordinator is available to answer technical and software questions related to PDS.

## E. CONFIDENTIALITY OF PSYCHOLOGY RECORDS

Much of the Psychology and DAP information stored in PDS is sensitive. Adequate safeguards should be taken to ensure that PDS data is not accessible to inmates and non-psychology staff. At a minimum all PDS data should be protected through the use of a computer password system. All Bureau computer security procedures should also be followed. For additional information on BOP computer security procedures, Program Statements entitled "Automated Information Systems Security" and "Personal Computers" are referenced.

## F. TRANSFER OF PSYCHOLOGY INFORMATION

The following procedural guidelines should be followed when an inmate is transferred to another correctional facility:

(1) When an inmate is in acute psychological distress (i.e., actively suicidal or psychotic) and is being transferred by emergency transportation or requires continuous monitoring by psychology staff, (i.e., is actively psychotic with medication compliance problems or is extremely agitated and/or assaultive), the treating psychologist will telephonically contact psychology staff at the receiving institution and those institutions where the inmate may reside while in transit and verbally transfer relevant psychological data in advance of the inmate's arrival. Written documentation summarizing relevant psychological findings and instructions for use during transfer should also accompany the inmate while in transit. Hard copies of relevant psychological data from the inmate's PDS record should also be mailed via certified or registered mail to the Chief Psychologist at the receiving institution.

(2) Psychology data documenting an inmate's involvement in psychological activities, such as individual and group psychotherapy or material collected during routine psychological assessment procedures, need not be forwarded when inmates are transferred to other correctional facilities. If the receiving institution requires this information at a later date, it can be requested from the PDS Coordinator who maintains this information in the national psychology archives. Information not contained in the PDS file (e.g., raw test data) may be requested from the Psychology

Department possessing this material.

(3) When an inmate is released, the PDS file should be forwarded to the PDS Coordinator who will maintain information regarding the delivery of psychological services to that inmate in the national psychology archives for a minimum period of 30 years from the date in which the inmate completes the full term of his or her sentence. Psychology information not contained in the PDS file (e.g., raw test data) should be maintained within the Psychology Department for a period of 30 years. Psychology files containing only routine psychological information (e.g., psychology screenings and segregation reviews) need not be saved since this information is already contained in the inmate's Central File.

* **G. MDS ASSIGNMENTS FOR MENTALLY DISABLED INMATES**

The Bureau has an ongoing interest in systematically gathering information about disabled inmates so that the needs of these inmates may be more effectively identified and addressed. The Americans with Disabilities Act of 1990 defines a "disability" as a permanent impairment or condition that includes:

(1) Any physical or mental impairment that substantially limits one or more major life activities;

(2) Any record of such impairment, or;

(3) Being regarded by others as having such an impairment.

Using these definitional criteria, there are three types of mental disability which fall under the domain of Psychology Services. These mental disabilities are defined as follows:

(1) Mental Illness. Any emotional or mental condition that substantially impairs the ability to function, defined according to criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), as follows: The presence or history of a major Axis I disorder and/or a severe Axis II disorder, along with either a history of or a current Axis V (Global Assessment of Functioning Scale) of 40 or below.

(2) Mental Retardation. A chronic and lifelong condition characterized by an IQ of 70 or below and concurrent deficits in adaptive functioning. Note: Organic Mental Disorders are included under mental illness as defined above.

(3) Learning Disability. A disorder in sensory, perceptual, or cognitive processes which interferes with the ability to learn in a conventional manner, and which substantially limits one or more major life activities.

The Bureau is committed to accommodating, wherever and whenever feasible, the special needs of the mentally disabled inmate. Accommodation is defined as anything done to meet the needs of a mentally disabled inmate to assist that inmate in the performance of one or more major life activity. Most accommodations for mentally disabled inmates will be provided through programs and/or services (e.g., medication, group therapy, case management, etc.) which are already in existence at the institution. However, on occasion, some special program, service, or "accommodation" may need to be provided or created to address the unique needs of a particular mentally disabled inmate. In still other cases, the mentally disabled inmate may not require any accommodation from the institution for his/her disability.

Several assignment categories are available in SENTRY's Medical Duty Status (MDS) Assignment System to report inmates with mental disabilities, as defined above, and to document levels of agency accommodation, as discussed above. These SENTRY MDS disability assignment categories are as follows:

(1) MDS Assignments for Mentally Ill Inmates.

| DESCRIPTION | ASSIGNMENT | GROUP CODE |
|---|---|---|
| Inmate is mentally ill, or has a history of mental illness, but requires no accommodation. | MNTL-NO AC | DM N |
| Inmate is mentally ill, has program needs to accommodate his/her disability, which are satisfied by already existing programs. | MNTL-PGM P | DMPP |
| Inmate is mentally ill, has program needs to accommodate his/her disability, which are satisfied by newly established programs. | MNTL-PGM N | DMNP |
| Inmate is mentally ill, has program needs to accommodate his/her disability which are unsatisfied. | MNTL-PGM U | DMUP |

(2) MDS Assignments for Mentally Retarded Inmates.

| DESCRIPTION | ASSIGNMENT | GROUP CODE |
|---|---|---|
| Inmate is mentally retarded, but requires no accommodation. | RETD-NO AC | DR N |
| Inmate is mentally retarded, has program needs to accommodate his/her disability, which are satisfied by already existing programs. | RETD-PGM P | DRPP |
| Inmate is mentally retarded, has program needs to accommodate his/her disability, which are satisfied by newly established programs. | RETD-PGM N | DRNP |
| Inmate is mentally retarded, has program needs to accommodate his/her disability which are unsatisfied. | RETD-PGM U | DRUP |

(3) MDS Assignments for Learning Disabled Inmates.

| DESCRIPTION | ASSIGNMENT | GROUP CODE |
|---|---|---|
| Inmate is learning disabled, but requires no accommodation. | LD-NO AC | DK N |
| Inmate is learning disabled, has program needs to accommodate his/her disability, which are satisfied by already existing programs. | LD-PGM P | DKPP |
| Inmate is learning disabled, has program needs to accommodate his/her disability, which are satisfied by newly established programs. | LD-PGM N | DKNP |
| Inmate is learning disabled, has program needs to accommodate his/her disability which are unsatisfied. | LD-PGM U | DKUP |

If an inmate has a mental disability and needs a program accommodation, which exists in the institution, but the inmate refuses the recommended treatment or program accommodation, he/she should be categorized according to his/her specific disability, and as "PGM P" (needs satisfied by already existing programs). In such cases, a note should be made in PDS as to the program accommodation recommended to the inmate and the inmate's refusal to participate. It is likely that inmates who do not engage in the full range of recommended treatment will still be receiving some program accommodation (e.g., special staff attention for monitoring the case).

The SENTRY disability assignment system does not provide an assignment for "no disability." Psychology Services will have no entry for an individual who is not mentally ill, mentally retarded, or learning disabled. In order to keep track of those inmates who have been screened and who have no disability, the psychologist will make a notation under the "Comments" section on the PDS intake screening form, such as, "This inmate has been screened for mental disabilities. No disability is evident."

Some psychologists may be aware that the number of disability/accommodation categories have been greatly reduced since the SENTRY **Disability Assignment System** was first introduced. Any inmate who was previously given a SENTRY assignment that no longer exists, should be converted to the disability category listed above that is most appropriate.

Procedures for implementing MDS Disability Assignments are as follows:

(1) Each inmate with one or more known mental disabilities shall be represented in SENTRY using the appropriate MDS assignment(s).

(2) Each inmate with a mental disability for whom an accommodation exists or is being made available shall be represented in SENTRY using the appropriate MDS assignment(s).

(3) When an inmate is transferred to another institution, the MDS assignment(s) automatically transfer(s) with the inmate.

(4) The PP34 Update Inmate Assignment (PP34) transaction shall be used to add, replace, or delete these assignments.

(5) A SENTRY roster of inmates with MDS disability assignments may be obtained by using the Group Codes presented in the charts on the preceding pages (pp.12-13).

(6) An inmate may have more than one disability and, therefore, may have more than one MDS assignment.

(7) Since a disability is, by definition, a permanent condition, it is unlikely that changes in Disability Assignments would have to be made. However, if an inmate's accommodation status changes, or if additional information indicates an erroneous earlier assignment, staff shall replace the initial assignment with the current, appropriate assignment.

The Chief Psychologist shall develop an institution plan to ensure that all inmates, who meet the criteria for mental illness, mental retardation, and learning disability, are entered into the SENTRY Disability Assignment System with the appropriate disability/accommodation assignment.

(1) Sentenced inmates shall be assessed, and mental disabilities and needed accommodations identified, at the initial intake interview after the inmate has reached his/her designated institution. Mental disability MDS assignments are not required for pre-trial or pre-sentenced inmates.

(2) The Chief Psychologist shall develop procedures to ensure that these assignments are entered into SENTRY within five working days after the interview date.

(3) Accuracy in the assignment of disabilities may require communication between Psychology Services and various departments in the institution (i.e., Health Services, Education, and the Unit Team). While the gathering of information may be necessary, actual data entry of the appropriate assignment for mental disabilities will be the Chief Psychologist's responsibility.

(4) The Chief Psychologist shall maintain overall responsibility for managing and updating these MDS assignments, should that become necessary. Any staff member who becomes aware of an inmate's needs due to a disability shall advise the Chief Psychologist to ensure that these needs are appropriately addressed.

(5) Case Managers must thoroughly review the Central File documentation to determine if the inmate has any physical or mental disabilities, and shall promptly advise the Chief Psychologist if any mental disabilities are known or suspected. The Case Manager shall also review the disability needs of inmates at scheduled program reviews, and make referrals if necessary. *

**PUBLIC RECORD INFORMATION**

Age
Convictions - previous federal, state, local
Court docket number
Date of birth
Date of commitment or release
Date sentence began
Date of execution of warrant
Date sentenced
FBI number
Fine(s) imposed
Full term expiration date
Full term expiration date less 180 days
Good time allowance and rate
Good time expiration date
How committed or discharged
Inoperative time
Institution of confinement (provided not confidential for protection)
Jail credit time
Judicial district of commitment
Judicial district of release
Mandatory release date
Name
Offense
Parole eligibility date and parole actions
Past movement via transfers or writs
Probation action
Race
Reason for change of sentence
Register number
Release destination
Sentence term
Sentence type
Sentencing judge's name
Sex
Special parole term
Time of commitment or release
Time served
Transfer destination - after the fact

# PRIVACY ACT -- DISCLOSURE GUIDELINES

| **DISCLOSURE WITHOUT CONSENT AND WITHOUT ACCOUNTING** | **DISCLOSURE WITHOUT CONSENT BUT WITH ACCOUNTING** |
|---|---|
| 1. Any record of inmate to employee of DOJ or consulting employee with need to know.<br>2. Public Record Information in response to formal FOIA request. Attachment 2-A lists disclosable Public Record Information.<br>3. Own records to inmate unless jeopardize:<br>(a) internal decisions or policy making.<br>(b) privacy rights of others.<br>(c) security, custody, or rehabilitation.<br>(d) expectations of confidentiality. | 1. To state & federal civil actions, or regulatory proceedings.<br>2. To state correctional agencies providing services to federal inmates.<br>3. To federal & state courts, court personnel, and probation officials.<br>4. To either House of Congress, Committees, or Congressman where inquiry at request of inmate concerned.<br>5. Oral disclosure of "public record information" to any third party.<br>6. To Bureau of Census for census or survey.<br>7. To National Archives or GSA for preservation of historical records.<br>8. To any person upon compelling circumstances affecting health or safety of individual inmate.<br>9. To Comptroller General or General Accounting Office.<br>10. Medical records may also be given to any physician, psychiatrist, state and federal medical facility personnel, other medical agencies providing continuing treatment for released federal offenders. |

| **DISCLOSURE WITH CONSENT AND WITH ACCOUNTING** | **DO NOT DISCLOSE -- EVEN WITH CONSENT** |
| --- | --- |
| 1. To attorneys, reporters, or callers who seek information. | 1. To a court, by appearing as witness or pursuant to court order subpoena - unless approval obtained from Asst. AG or Director. (See 28 CFR 16.22 et seq). Refer all such requests to Regional Attorney. |
| 2. To treatment agencies, social agencies, etc., not considered law enforcement agencies. | 2. Anything from the following: (a) Pre-sentence report; (b) psychiatric or psychological studies; (c) FBI or other investigative reports; (d) studies prepared for sentencing court. |
| 3. To researchers, students, survey groups, etc., unless information is released without identification of inmates, either by name, number, or other individual identifying characteristics. | 3. Contents of reports on convicted prisoner by U.S. Attorney or court. |
| 4. To family, friends, interested citizens, clergymen, etc., unless compelling health or safety considerations are present. | 4. Staff memos containing opinions, evaluations, or subjective conclusions. |
| 5. To credit agencies, loan companies, prospective employers, collection agencies, etc. | 5. Intelligence reports concerning escape plots, contraband introduction, assaults, disturbances, or disciplinary investigations. |
| | 6. Any information or documents concerning informers, witnesses against inmates, or which pertain to a third party who has a legitimate expectation of confidentiality. |
| Note: Information disclosed with inmate consent should not be disclosed unless it would also be releasible to inmates themselves. Under Privacy Act all consents must be in writing. Oral consent is not sufficient. | |

**INFORMED CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, _____, Register No. _____

hereby authorize:

_____

_____

_____

to release confidential information concerning my medical, psychological, and/or substance abuse evaluation and/or treatment to:

_____

_____

_____

_____

for the purpose of:

_____

_____

The doctrine of informed consent has been explained to me and I understand that there are statutes and regulations protecting the confidentiality of medical/psychological/substance abuse evaluation and treatment information. I understand that the information I am consenting to be release consists of such protected information. The need for this information has been explained to me, and I give my consent for release. I hereby state that this consent is truly voluntary. This consent is valid until this request is fulfilled, but not to exceed 60 days. I further understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

_____ _____
Signature Printed Name

_____ _____
Signature of Witness Date

(This form may be locally reproduced or replicated via wordprocessing)

BP-519 (53)
May 1993

# CHAPTER 3

# TREATMENT OF THE MENTALLY ILL INMATE

## 3.1 STRATIFIED SERVICE DELIVERY MODEL

The Bureau of Prisons offers a stratified approach for the delivery of mental health services to mentally ill inmates. This stratified approach is comparable in many ways to the system of mental health care found in most communities. In such systems, severely disturbed individuals are cared for in inpatient treatment facilities. Less disturbed individuals typically receive ongoing care in less restrictive environments such as day hospitals, halfway houses, or outpatient mental health facilities.

Within the Bureau of Prisons, inpatient psychological and psychiatric services are available for inmates with severe mental illness through placement in one of the Bureau's Medical/ Psychiatric Referral Centers. Inmates referred to one of these facilities are often in extreme psychological distress; are unable to function in a general prison population; and are typically in need of psychotropic medication, a more therapeutic milieu, and intense clinical monitoring/supervision.

Inmates not in need of inpatient treatment services are managed on an outpatient basis through contacts with the Psychology Services Departments found at each institution. Similar to mental health clinics located in the community, Psychology Departments at each institution are designed to meet the unique needs of the inmate population within the larger context of the institution's overall mission. For example, at MCC/MDCs where inmates are housed briefly pending trial or sentencing, a central treatment focus might consist of crisis intervention and the management of severely disturbed inmates. At Camps, where sentences tend to be short, the treatment focus might consist of brief counseling or pre-release planning. At regular institutions where sentence length varies considerably, a broader range of treatment activites may be offered.

Similar to the community, the vast majority of mental health treatment for sentenced inmates in the Bureau is provided at the local institutional level by Psychology Services in collaboration with either a full-time or consultant psychiatrist. When inmates present behaviors requiring assistance beyond the scope of services available at the local level, referral to a psychiatric referral center becomes necessary. Once the inmate/patient is stabilized and his or her treatment has reached a level of maximum gain at the psychiatric referral center, the inmate is discharged and returned to the referring institution for

outpatient care. In some cases, an inmate may be discharged through a transitional care facility which functions as a mental health "halfway house" between the psychiatric referral center and the receiving institution. Currently, one Transitional Care Unit is in operation at FCI, Petersburg, Virginia.

## 3.2 SERVICES FOR MENTALLY ILL INMATES AT REGULAR FACILITIES

Without the effective management at the institutional level of most inmates with histories of severe psychological disturbance, the Medical/Psychiatric Referral Centers would be rendered completely helpless to meet the pressing need for treatment beds. Therefore, it is incumbent on Psychology Services at the local level to develop an effective strategy for managing those inmates in the general population who require ongoing mental health services. Very often, this strategy involves working closely with the Medical Department and the staff or contract psychiatrist. Effective strategies are not limited to evaluation and professional clinical care, but include education of staff in identifying signs and symptoms of mental illness and reinforcing therapeutic interventions by line staff.

### A. PSYCHIATRIC SERVICES

According to the Health Services Manual, it is recommended that each institution not having a full-time psychiatrist employ a consultant available to meet the needs of inmates requiring psychiatric medication. If a psychiatrist is not available, Psychology Services at the institutional level should work closely with the Health Services Administrator to hire a psychiatrist who can assist in establishing an overall effective, integrated mental health program for the institution. Team work between the disciplines of psychiatry and psychology can effectively and economically treat psychologically disturbed inmates who might otherwise require transfer to a psychiatric referral center.

### B. IDENTIFICATION AND TREATMENT OF MENTALLY ILL INMATES

The severely disturbed inmate has a great potential for disruption in the institution and typically possesses an acute need for treatment. It is imperative, therefore, that this special population be closely monitored. Good management and care includes accurate and early identification, the implementation of effective treatment programs, and, in the case of severe mental disorder, a timely referral to an appropriate referral center. Psychologists are often the only trained mental health experts on site in many institutions and accordingly have a significant responsibility for dealing with this special population.

(1) Identification Considerations

The initial step in the planned treatment of the mentally ill inmate is the accurate identification of the inmate's condition and status. Severely disturbed inmates will come to the attention of institution psychologists in a variety of ways: as a result of the careful initial screening of new admissions by case managers, physician assistants, and psychologists themselves; by referral from other institutional staff, particularly Health Services; and, by notification from Psychology Services in other BOP facilities that a potentially disturbed individual is in transit.

(a) It is imperative that psychologists maintain openchannels of communication with line staff in their institution, as unit officers or detail supervisors will often be the first to recognize aberrant behavior among those they supervise.

(b) To insure continuity of care, all inmates received from a psychiatric referral center should be interviewed by a member of the psychology staff immediately after being returned to the institution and prior to release to the general population.

(c) For accountability and ready reference purposes, the Chief Psychologist or his designee should develop a system (e.g., a log) for identifying and monitoring those inmates received from any psychiatric referral center (this system should specify which inmates are receiving medication for mental health reasons, which inmates will require special monitoring, and which inmates will require additional treatment).

2. Treatment Considerations

The management and treatment of the severely mentally ill inmate is a task requiring the cooperative efforts of many. In most institutions psychologists assume primary responsibility for coordinating those efforts. However, a total effort is required from many persons and departments. There are certain changes and occurrences in an institution that are known to unduly affect a severely mentally ill inmate. It is required that Psychology Services notify appropriate staff if they believe that a mentally ill or mentally retarded inmate will be affected by: 1) housing changes; 2) program assignment changes; 3) disciplinary action; or 4) transfer to another institution.

(a) Housing of Mentally ill Inmates

Members of Psychology Services need to work closely with staff in determining housing needs for mentally ill inmates. The goal is to maximize treatment potential while striving to maintain the safety of the inmate and others. Psychologists should be consulted about the need for a single cell or whether a particular inmate or type of inmate could be an appropriate cell partner. In those instances where it is concluded that the inmate will not be able to handle the demands of the general population and no sheltered alternative exists, the institution's Executive Staff should be informed and a written evaluation prepared recommending an appropriate transfer.

(b) Active Treatment Process

Psychology Services staff are responsible for the assessment and treatment of mentally ill inmates. This responsibility is shared with other trained mental health staff, such as a psychiatrist, if one is available. A treatment plan should be formulated and executed for all inmates diagnosed with significant mental disturbance. In cases where inmates receive or are assessed as in need of medication for mental illness, Psychology Services staff should consult regularly with the Clinical Director of Health Programs to insure that a comprehensive and effective treatment regimen exists and is followed.

## C. PSYCHOTROPIC MEDICATION CONSIDERATIONS

Although psychologists are not legally or ethically authorized to prescribe medications, it is necessary for them to have an understanding of the legal constraints upon the use of psychiatric medications in the institutional setting. This is of importance since psychologists typically assume and are usually held responsible for the overall treatment of mentally ill inmates in most institutions. In that role psychologists are often called upon to monitor and exercise their influence as a resource to ensure that abuses of medications do NOT occur.

Through a series of legal decisions, a relatively clear set of guidelines has emerged which has established accepted parameters within which psychotropic medication should be used. Clearly, these are only guidelines, but actions outside these parameters should be well documented and professionally justified. In general, psychotropic medication should be administered for a diagnosable psychiatric disorder and should be viewed as the accepted method of treatment for that disorder. Psychotropic medication is not designed for, nor should it be used as, a method of chemical restraint to control behaviors unrelated to mental illness.

Psychotropic medication can be administered on either a voluntary or emergency basis.

(1) Voluntary Medication

If an inmate is to receive psychiatric medication voluntarily, the physician must ensure that the patient's informed consent is thoroughly documented. Also, it must be made clear that the inmate possesses sufficient capacity and judgement to make an informed consent about taking the medication. The consent must minimally include documentation that prior to giving consent, every effort was made to explain to the inmate why the medication was necessary, how it could improve his or her condition, the possible side-effects, the consequences of not taking the medication, as well as any alternative forms of treatment deemed appropriate. All of these aspects of informed consent should be documented in the inmate's medical file. The "Informed Consent for Medication" form found in the Health Services Manual should be used to document the inmate's consent to receive psychiatric medication.

(2) Involuntary Medication

If an inmate is to receive psychiatric medication involuntarily, an emergency situation must exist in which the inmate is clearly posing a threat to himself or herself or others. In that situation, the physician must be prepared to testify that the medication being given constitutes an appropriate treatment for the mental illness for which the inmate is diagnosed and that less restrictive alternatives were not available, were ineffective, or were contraindicated. Less restrictive alternatives typically would include: seclusion, physical restraint, and the use of minor tranquilizers prior to the use of neuroleptic medications.

(3) Emergency Treatment and Emergency Referral

Emergency treatment with psychiatric medication will ordinarily not be continued for more than 72 hours outside a Psychiatric Referral Center. In addition, long acting medications such as Prolixin and Haldol Decanoate should not be used in emergency situations since their effects exceed the 72 hour time period. When psychiatric medication is used in emergency situations, documentation should include the clinical diagnosis, the nature of the perceived threat or dangerousness, and justification that less restrictive methods were shown to be ineffective. Following the immediate situation, an emergency referral to a Psychiatric Referral Center for further evaluation and possible treatment should be initiated, with every effort made to effect the transfer within the 72 hour time frame.

Psychiatric medication prescriptions should ordinarily follow a recognized, widely accepted standard such as that described in the Physician's Desk Reference. Polypharmacy should rarely occur and any departures from the standard medical practice should be justified in the medical record. Additionally, efforts should be made to maintain patients on the lowest effective dose of the medication. All patients on medication for mental health problems should be monitored regularly for the effectiveness of the medication as well as side effects. This is particularly important for medications known to potentially cause tardive dyskinesia.

For more detailed information about psychotropic medication issues, Section 6607 of the Health Services Manual and the Program Statement on "Use of Force and Application of Restraints on Inmates" are referenced.

## 3.3 REFERRAL AND TRANSFER TO PSYCHIATRIC REFERRAL CENTER

### A. APPROPRIATENESS OF TRANSFER

The philosophy of the BOP is to attempt to treat all mentally ill inmates within their designated facility. However, on occasion, despite the best efforts to work with mentally ill inmates at the local institutional level, there will be those who require more intensive mental health services. These inmates are typically referred to one of the Bureau's Psychiatric Referral Centers for acute psychiatric care. Acute psychiatric care is defined as care, including but not limited to, crisis intervention for inmates who are suicidal, homicidal, or are unable to function in the institution without creating dangerous situations due to their mental illness.

Decisions concerning the appropriateness of a transfer to a psychiatric referral center are based on the best judgment of the treating clinician (i.e. psychologist, staff psychiatrist, or consulting psychiatrist) and are typically dependent upon such factors as the severity of the mental disorder, the specific characteristics and resources of the institution, and relevant patient variables. Inmates who are disruptive to the orderly running of the institution, but who are not mentally ill, are not generally appropriate referrals to the Bureau's Psychiatric Referral Centers.

## B. REFERRAL CRITERIA TO PSYCHIATRIC REFERRAL CENTERS

For the most part, each of the Psychiatric Referral Centers receives inmates from regular institutions in one of two basic categories, (1) inmates requiring intensive treatment and (2) inmates whose release from custody would pose a substantial risk to the community.

(1) Inmates Requiring Intensive Treatment

The vast majority of referrals to the Psychiatric Referral Centers concern inmates who require more intensive treatment than can be provided in a regular Bureau of Prisons facility. The operational standard for referral is based upon the clinical judgment of the institution psychologist or psychiatrist who believes that an inmate suffers from a mental illness or defect which requires hospitalization, and that the inmate cannot be effectively treated or managed in a regular institution.

(2) Inmates Who Pose a Substantial Risk to the Community

Title 18, U. S. Code, Section 4246 describes procedures for retaining an inmate beyond his or her release date if the inmate suffers from a mental disease or defect, such that release would cause substantial risk of bodily injury to another person or serious damage to the property of another.

(a) For this provision of the law to be enacted, the inmate **MUST** be hospitalized in a psychiatric facility. In addition, the risk must be CAUSALLY related to the inmate's mental disease or defect.

(b) It is the current legal consensus that the process outlined in Title 18, U.S. Code, Section 4246 should be used rarely and only in cases where substantial and present danger can be clearly established. In cases where a question concerning the appropriateness of such a referral exists, it is advisable to consult with the Chief of Psychology Services at one of the Referral Centers for guidance.

(c) In cases where such referrals are appropriate, the inmate should be referred to the Referral Center no less than 120 days prior to his or her release date, due to the length of the subsequent court process which will be initiated. However, in cases where an evaluation must be made in a shorter period of time, an emergency referral should be made to the Referral Center.

## C. TRANSFER PROCEDURES TO PSYCHIATRIC REFERRAL CENTERS

Transfers to Psychiatric Referral Centers fall into one of three categories: routine, routine urgent, and emergency. All transfer procedures are originated by the treating clinician at the institution after consultation with the institution's Chief Psychologist, Clinical Director for Health Programs, and Warden. It is recommended that the treating clinician be directly involved in all aspects of the mental health transfer process in order to expedite procedures, enhance communication, and maintain an adequate degree of professional oversight.

The transfer process begins when the treating mental health clinician concludes that an inmate requires further evaluation or treatment beyond the capabilities and resources available at that institution. The decision to initiate a referral is ordinarily based upon the inmate's tentative diagnosis, evaluation needs, and potential treatment strategies. After the mental health clinician has decided that a referral is warranted and has received the concurrence of the Warden, the clinician's findings, along with any medical concerns from the Clinical Director for Health Programs, should be transmitted to the receiving Referral Center. The referral should be processed regardless of the inmate's consent to be treated. Responsibility for implementing the procedures presented in Title 18, U.S. Code, Section 4245, Transfer of a Sentenced Inmate for Psychiatric Treatment, rests with each Psychiatric Referral Center and not with regular institutions.

(1) Routine Transfers

To make routine referrals, the institution clinician will complete SENTRY Message #204, label the referral as routine, and transmit the SENTRY message to the Medical Designator for the Bureau of Prisons with a copy to the institution's Clinical Director for Health Programs. Upon reviewing the material, the Designator will determine if the referral is appropriate and assign the case to one of the Psychiatric Referral Centers. However, even after the referral has been initiated, the clinician should continue to follow the case to ensure that the inmate does not decompensate further while awaiting transfer.

(2) Routine Urgent Transfers

A routine urgent transfer is one in which the inmate needs to be at the Psychiatric Referral Center within 14 days (e.g., slowly decompensating inmate who refuses psychotropic medication). Routine urgent transfers are referred for transer using the same procedures outlined above for routine transfers. Routine urgent transfers should not be transported via regular BOP methods of transportation. Rather, they should be transported via special transportation such as air ambulance, air charter, special van, etc.

(3) Emergency Transfers

Emergency transfers are made on a Warden-to-Warden basis. These cases should be referred to the most appropriate Referral Center based upon security/custody requirements, treatment resources available, proximity, and Referral Center bed space. These cases, due to their typically serious nature, require considerable coordination with the Referral Center as well as other institution staff. As such, it is important that the treating clinician make every effort to ensure that all necessary transfer arrangements are made as expeditiously as possible.

(a) It is advisable for the institution clinician to contact the Referral Center by telephone to discuss the case in detail (including any medical concerns voiced by the institution's Clinical Director for Health Programs) prior to initiating the transfer process. Following this telephone contact, the treating clinician at the referring institution will complete SENTRY message #204, label the case as being an emergency referral, and transmit the message to the appropriate Referral Center with a copy to the Medical Designator. It is essential that the SENTRY message be

completed in considerable detail before the referral center makes the final acceptance decision. The accepting Referral Center will be responsible for notifying the Medical Designator of the acceptance via SENTRY notification.

(b) Psychiatric emergency cases must not be transported via regular Bureau of Prisons methods of transportation. All emergency cases must be transported by special transportation such as air ambulance, air charter, special vans, etc. Any case that can be moved by regular methods of transportation should not be considered to require an emergency move, but rather, should be referred to the Medical Designator for routine transportation.

(3) Transfer Security Needs

When inmates need to be transported to a psychiatric referral center, treatment staff and security personnel should cooperate in determining conditions of transportation and necessary security precautions. Both treatment and security needs should be considered when establishing transportation and transfer procedures.

(4) For additional information on the referral process, the Health Services Manual, Section 6822, is referenced.

## 3.4 SERVICES FOR MENTALLY ILL INMATES AT PSYCHIATRIC REFERRAL CENTERS

The mission of the Bureau's Psychiatric Referral Centers is to provide inpatient psychiatric hospitalization to individuals who cannot receive sufficient treatment at regular Bureau facilities. In addition to the primary treatment mission of these institutions, they, along with the Bureau's Forensic Study Sites, also conduct comprehensive psychiatric and psychological evaluations for the U.S. Courts to include opinions concerning competency to stand trial and responsibility for criminal conduct. The functional organizational plan at each Center is relatively independent from the others, enabling each institution to best use its unique characteristics to meet its mission.

## A. STANDARDS

The Bureau has demonstrated a commitment to providing care and treatment to patients at its Psychiatric Referral Centers which equals that found in the community. This commitment requires Psychiatric Referral Centers to conform to the standards established by the Joint Commission on the Accreditation of Hospital Organizations (JCAHO). The JCAHO is the primary accrediting body for hospitals in the United States, and as such, sets the standard for patient care. Satisfying JCAHO standards helps to ensure a high quality of care for inmates and also maintains the integrity and public image of the Bureau of Prisons with its constituents.

## B. INVOLUNTARY HOSPITALIZATION

Title 18, U.S. Code, Section 4245 gives the person the right to refuse involuntary psychiatric treatment, including admission to a psychiatric hospital prior to a formal court hearing. While an inmate may be identified and transferred to a psychiatric referral center from a local institution, he or she may exercise the right to refuse admission and/or treatment upon arrival or at any period during treatment. The only exception to this statute would be when the inmate's behavior constitutes an emergency which includes imminent danger to self, others, or government property; in those cases treatment may proceed prior to a hearing.

While the proceedings for a hearing under the provisions of Section 4245 occur only at Psychiatric Referral Centers, clinicians at the referring institution serve an important function in the smooth transition of the inmate to the referral center. Mental health clinicians are encouraged to explain to the identified inmate, to the extent possible, considering his or her mental illness, his or her rights under Section 4245. Empathic explanation of the proceeding may lessen the inmate's fear and suspicion of the proposed treatment process.

The referring mental health professional should also recognize that once a referral to a Psychiatric Referral Center is made, should the referral center need to utilize Section 4245 for involuntary commitment, all records become open to the court. This means that records from other institutions will be scrutinized by the Assistant U.S. Attorney, defense attorney, other mental health experts, and the court. It is therefore, critically important that the records be thorough, and that all actions be well documented. If one of the Psychiatric Referral Centers has to file a petition under Section 4245, it is also very valuable to have as much information as possible from the referring institution about the inmate's symptoms and behavior prior to transfer. The intent of Section 4245 is to assure that inmates are afforded due process prior to admission or treatment in a psychiatric hospital.

## C. DANGEROUSNESS COMMITMENT PROCEDURES

Title 18, U.S. Code, Section 4246 establishes a procedure for inmates scheduled for release who are dangerous and are mentally ill. This statute has relevance for clinicians practicing outside Psychiatric Referral Centers. Occasionally, an inmate will approach a release date and also display signs of mental illness. If the inmate is dangerous because of his mental illness, staff should request an evaluation as stipulated under provisions of Section 4246. If the inmate is found to suffer from a mental disease or defect such that his or her release would present a substantial risk of bodily injury to another person, or serious damage to property of another, that person may be retained beyond his release date. A detailed outline of this procedure can be found in the Health Services Manual; however, the major points are reviewed below.

An inmate must be hospitalized prior to initiating any 4246 proceeding. This requires that an inmate be transferred to a Psychiatric Referral Center.

There are four criteria an inmate must meet prior to being considered for filling a Section 4246 action:

(1) They must suffer from a serious mental disease or defect, generally a DSM-III-R, Axis I diagnosis.

(2) They must present a danger to another person or the property of others if released to an unstructured environment.

(3) The finding of dangerousness must be causally related to the mental illness.

(4) No suitable state placement can be found.

As is the case with any issue related to the management and treatment of mental health cases, it is advisable to consult with mental health staff at a Psychiatric Referral Center. Telephone contact is particularly helpful in reviewing specific admission criteria, treatment regimen, and related forensic issues.

## 3.5 RETURNING PSYCHIATRIC REFERRAL CENTER CASES TO REGULAR INSTITUTIONS

A primary objective of the Psychiatric Referral Centers is to treat inmates until they become sufficiently stable to function adequately in a regular institution. Except under unusual circumstance, all inmates transferred to one of the Referral Centers will be returned to their initial referring institution. When a mentally ill inpatient has improved sufficiently to be transferred, the patient's treatment plan will be closed and a transfer summary dictated. The transfer summary will contain a brief review of the patient's course of treatment, diagnosis, and continuing treatment recommendations. This information is then incorporated into the Warden-to-Warden letter from the Referral Center to the receiving institution. Psychologists at the receiving institution are encouraged to read the Warden-to-Warden letter as well as the transfer summary on each returning inmate. If questions exist concerning treatment issues, institution psychologists should contact Referral Center staff for more details about the case.

Inmates who no longer require the intense level of care provided at the Psychiatric Referral Centers, but who do need a level of supervision and clinical monitoring beyond that routinely provided at most institutions, may be referred to a Transitional Care Unit (TCU). TCUs are designed to provide an intermediate level of care and to assist inmates in their return to regular correctional facilities. Ordinarily, an inmate's stay at a TCU will be approximately 90-120 days. TCU treatment staff work to educate inmates about their particular illness and medication needs, stress medication compliance, and teach skills useful to the inmate in making a better adjustment to his or her illness and correctional surroundings.

Referrals to TCUs are only accepted from the Psychiatric Referral Centers following a successful course of treatment. Inmates housed in regular institutions who may be appropriate for referral to a TCU must first be evaluated and/or treated at one of the Psychiatric Referral Centers.

# CHAPTER 4

# ROUTINE MENTAL HEALTH SERVICES

## 4.1 INITIAL PSYCHOLOGICAL INTAKE SCREENING PROCESS

Initial psychological screening is minimally defined as the performance of a clinical interview by a licensed or license-eligible psychologist or psychology graduate student working under the supervision of a licensed or license-eligible psychologist. As time and resources permit, a psychological screening may be enhanced through behavioral observations, a review of available historical information found in the Central File or through Sentry, and psychological testing, when deemed appropriate by a psychologist.

### A. PURPOSES OF PSYCHOLOGICAL INTAKE SCREENINGS

Psychological intake screenings are conducted for the following purposes:

(1) To identify emotional, intellectual, and/or behavioral problems;

(2) To identify specialized treatment needs (e.g., suicide watch, drug abuse treatment, psychotropic medication monitoring, etc.);

(3) To provide baseline data for use by psychologists during future contacts with inmates;

(4) To provide useful information to correctional and unit staff (e.g., assault potential, escape risk, potential adjustment problems, inmate strengths, special housing/program needs, etc.);

(5) To provide information for other decisions specific to particular institutional missions and goals; and

(6) To inform inmates about Psychology Services staff and programs.

### B. PSYCHOLOGICAL INTAKE SCREENING PROCEDURES

All individuals entering a Bureau of Prison's facility must be medically screened by a Physician's Assistant within twenty-four hours. Physician's Assistants are trained and required to screen for signs of psychological disturbance (e.g., reports of mental health treatment history, suicidal behavior, psychotic symptoms) as part of the general medical screening. When psychological disturbance is suspected, Physician's Assistants should refer the inmate to Psychology Services staff for prompt and appropriate disposition.

In addition to the preliminary medical screening process described above, **all inmates designated to FCIs, USPs, and FMCs** (except those inmates admitted for in-patient treatment), **and work cadre inmates at MCC/MDCs,** will be psychologically screened using the procedure specified below. (Inmates admitted to medical/psychiatric facilities for in-patient treatment will be screened in accordance with JCAHO standards.)

(1) Within their first 14 days at the facility (30 days for transferred inmates), all inmates will be:

(a) asked to complete the Psychology Services Inmate Questionnaire (Attachment 4-A);

(b) interviewed by a member of the Psychology Services staff qualified to conduct a clinical interview; and

(c) psychologically tested, if such testing is judged necessary by the psychologist.

The Psychology Services Inmate Questionnaire will be reviewed by the psychologist prior to completion of the screening interview. Questionnaires should be retained in a file within the Psychology Department for future reference.

(1) A PDS-generated, Psychology Services Screening Report will be completed on all newly committed inmates and forwarded for inclusion in their Central File within the inmate's first 30 days at the institution. For transferred inmates, the PDS-generated, Psychology Services Screening Report will be completed and forwarded for inclusion in the inmate's Central File within the inmate's first 45 days at the institution. A file copy of this Screening Report will remain in the inmate's PDS record. In preparing this Screening Report, the psychologist may wish to utilize data on the inmate from other sources such as the inmate's Central File. In those rare cases where the psychologist determines that material presented in the Screening Report should not be disclosed to the inmate, the psychologist should stamp the Screening Report "FOI Exempt" prior to forwarding the Report for inclusion in the Central File.

(2) Any raw test data generated as a result of the screening process will be maintained in either a single reference file or separate folders within the Psychology Department.

In addition to the preliminary medical screening process described above, **Pre-Trial or Pre-Sentence detainees housed in MCCs, MDCs, or Jail Units and all inmates designated to FPCs** will be asked to complete the Psychology Services Inmate Questionnaire (Attachment 4-A) within their first 24 hours at the facility. The Chief Psychologist is responsible for developing a procedure to insure that each inmate receives this screening questionnaire within the appropriate time frame. The staff member assigned to review the screening questionnaire shall note the detainee's/ inmate's response to question 29. This question refers to the presence of suicidal thoughts or feelings. The staff member will promptly refer all detainees/inmates who positively endorse this question to the Suicide Prevention Program Coordinator. Inmates/detainees who request psychological services by positively endorsing question 40 will also be seen promptly for assessment by a member of the Psychology Department. All other questionnaire responses will be reviewed by Psychology staff, with appropriate, timely, followup screening interviews/services being offered to those detainees/inmates where significant problems are suspected. On those cases where followup psychological interviews/services are provided, a Psychology Services Screening Report should be completed on PDS with a copy forwarded to the detainee's Pre-trial Information Packet or the inmate's Central File within the first 30 days of the detainee's/inmate's arrival at the facility. A file copy of this Screening Report will remain in the detainee's/inmate's PDS record.

For **individuals in holdover status**, a preliminary screening by a Physician's Assistant is sufficient, unless a significant problem is identified. Individuals referred to Psychology Services as a result of this preliminary medical screening process should be evaluated promptly by a psychologist. Details of that evaluation, including a description of the problem and recommended corrective actions, should be documented in PDS under the appropriate contact heading. If, in the clinician's judgment, such information is necessary to insure that the inmate's mental health needs are appropriately met throughout the "in transit" process, the PDS contact note should be printed in memo format and placed in the inmate's Central File or Pre-Trial Information Packet. To fully evaluate the mental health

status/needs of the referred holdover inmate, it may be necessary to contact Psychology Services staff from the institution where the inmate was last housed. If the inmate will subsequently be sent to an institution other than where he was last housed, it also may be necessary to contact Psychology Services' staff at the receiving institution to discuss the disposition of the case.

All PDS-generated screening reports completed by Psychology Students, Predoctoral Interns, or Postdoctoral Residents will be reviewed and initialed by a licensed member of the Psychology staff prior to being sent to the detainee's Pre-Trial Information Packet or the inmate's Central File.

## 4.2 PSYCHOLOGICAL REVIEW OF DETENTION/SEGREGATION INMATES

The Bureau of Prisons recognizes that extended periods of confinement in Administrative Detention or Disciplinary Segregation Status may have an adverse effect on the overall mental status of some individuals. Therefore, all inmates confined in either Administrative Detention or Disciplinary Segregation status for 30 consecutive days or longer will be psychologically evaluated.

### A. DETENTION/SEGREGATION REVIEW PROCEDURES

At least one member of the Psychology staff will visit the Special Housing Unit (SHU) on a weekly basis and document this visit with an appropriate notation in the SHU visitor's log. The purpose of these visits is to be available to SHU inmates and staff regularly in the event relevant questions or concerns need attention. It is also Psychology Service's responsibility to monitor the Detention/Segregation Unit roster to ensure that inmates needing detention/segregation psychological reviews are identified and scheduled for assessment in a timely manner.

For those inmates housed in Administrative Detention or Disciplinary Segregation for thirty days or longer, a psychological assessment will be completed at 30 day intervals. This assessment will address the inmate's adjustment to the surroundings and the threat posed to self, staff, and other inmates. Although a standardized reporting format is available through PDS, the psychologist will make additional appropriate comments regarding specific inmate behavior and/or emotional stability as warranted by the situation.

Copies of the PDS-generated, detention/segregation review report should be sent to the Captain and to the inmate's unit team for inclusion in the inmate's Central File. A file copy will also remain in the inmate's PDS record.

Detention/Segregation Review Reports completed by Psychology graduate students, Predoctoral Interns, or Postdoctoral Residents should be reviewed and initialed by a licensed member of the Psychology Services Staff prior to distribution to other departments.

The Chief, Psychology Services will review the Detention Unit Roster on a periodic basis to verify that all reports are being completed in a timely manner.

## 4.3 DIRECT CLINICAL SERVICES TO INMATES

All inmates have access to direct clinical services from the Psychology Department. Ordinarily, these services include: crisis intervention; brief counseling focused on a specific issue or problem; individual and/or group psychotherapy, and psychoeducational group programs. Inmates may access these services through self-referral or may be referred by institution staff.

### A. CRISIS INTERVENTION

Crisis referrals will receive immediate attention. If, following more comprehensive assessment, it is decided that the inmate requires a transfer or a change in housing to address mental health needs, that recommendation must be made in writing by the assessing psychologist on PDS under the appropriate contact heading and in memo format for use in notifying appropriate staff.

Case notes describing each crisis contact should be documented in PDS on the inmate's Chronological Record under "Other Contacts - Crisis Intervention".

### B. BRIEF COUNSELING

Often, inmates will approach a psychologist with a specific problem situation which will require several sessions to address appropriately. On other occasions, a crisis referral may require several followup sessions to adequately remedy the problem. These types of sessions are defined as Brief Counseling sessions and ordinarily do not exceed four to five sessions. Inmates approaching a psychologist with requests for assistance in making more significant lifestyle or personality changes should be assessed to determine their suitability as individual and/or group psychotherapy candidates.

Case notes describing each brief counseling session should be entered into PDS on the inmate's Chronological Record under "Other Contacts - Brief Counseling".

## C. INDIVIDUAL AND GROUP PSYCHOTHERAPY

The clinical decision to engage an inmate in individual or group psychotherapy is the prerogative of the individual psychologist and is contingent upon such factors as the type of psychological problem(s) diagnosed, the professional expertise of the psychologist, the motivation of the inmate to participate in treatment, departmental staffing level, and departmental priorities.

(1) Each Chief Psychologist is responsible for assessing the treatment needs of the inmate population on an annual basis and for determining what methods of treatment (i.e., individual and/or group psychotherapy) will best meet these assessed needs. Each Chief Psychologist should use PDS's Annual Summary Report of Inmate Involvement in Psychology Services Activities to assess the treatment needs of the inmate population.

(2) Documents related to treatment will be accumulated whenever an inmate is seen regularly in individual or group psychotherapy sessions. At a minimum, treatment records will include:

(a) A "Treatment Plan/Consent to Treatment" Form agreed to and initialed by the inmate. These forms can be generated through PDS. Initialed Treatment Plans/Consent to Treatment Forms should be kept on file in the Psychology Department.

(b) A chronological record of contacts for individual therapy sessions should be documented in PDS on the inmate's chronological record under "Other Contacts - Individual Therapy".

(c) A chronological record of contacts for group therapy sessions should be documented on PDS's Main Menu under "Treatment Groups".

## D. PSYCHOEDUCATIONAL GROUPS

Psychoeducational groups are defined as group programs aimed at educating inmates regarding specific psychological issues or at training inmates in specific psychological skill areas. Examples of psychoeducational groups include: Women's Issues Groups, Assertiveness Training Groups, Interpersonal Communication Groups, Stress Management Groups, Smoking Cessation Groups, and Weight Management Groups.

For documentation purposes, psychoeducational groups, when offered, should be handled in the same way as psychotherapy groups.

## E. PDS FILE ENTRIES MADE BY PSYCHOLOGY STUDENTS, INTERNS, AND/OR RESIDENTS

PDS case notes on crisis contacts, brief counseling sessions, and individual therapy sessions made by Psychology students, Predoctoral Interns, or Postdoctoral Residents should be reviewed weekly by their clinical supervisor. The clinical supervisor should indicate that these notes have been reviewed and discussed with the student, interns, or residents with a brief comment in the inmate's PDS file under "Evaluations and Reports".

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

**PSYCHOLOGY SERVICES**
**INMATE QUESTIONNAIRE**

[redacted]

1. First Name:_____ 2. Last Name:_____

3. Register Number:_____ 4. Today's Date:_____

5. Housing Unit:_____ 6. Case Manager: _____

7. Date of Birth: _____ 8. Sex: Male___ Female___

9. Race/Ethnicity: White___ Black___ Asian/Pacific___ Hispanic____
American Indian___ Other___, Specify:_____

10. Marital Status: Married___ Common Law___ Never Been Married____
Divorced___ Separated___ Widowed____

11. Number of Children:_____ 12. Ages of Children: _____

13. Highest Grade Completed in School:_____

14. Main Occupation: _____

15. Hometown/State/Country: _____

16. Have you ever served in the military: Yes___ No___

17. Current Offense/Charges: _____

18. Sentence Length: _____ 19. Time Already Served on Sentence:_____

20. Total Time in Jail and Prison During Life:_____

21. Have you ever received treatment for a nervous or mental problem?
Yes___ No___

22. If yes, when? _____

23. If yes, where? _____

24. Have you ever taken or are you now taking any medication for a nervous or mental problem? Yes___ No___

25. If yes, when? _____

26. If yes, what medication(s)? _____
_____

**** PLEASE CONTINUE ON BACK SIDE ****

27. Have you ever seriously considered suicide? Yes___ No___

28. Have you ever attempted suicide? Yes___ No___

29. Are you seriously considering suicide now? Yes___ No___

30. Have you ever committed a violent act such as an assault, rape, armed robbery, or murder? Yes___ No___

31. Have you ever received any incident reports for fighting or assault while you were locked up? Yes___ No___

32. Have you ever been accused of threatening a government official? Yes___ No___

33. Check any of the following you used in the two years before arrest:

| | | |
|---|---|---|
| Amphetamine/Speed ___ | Heroin/Morphine ___ | Marijuana ___ |
| Glue/Solvent/Inhalants ___ | LSD/Psychodelics ___ | Tobacco ___ |
| Sleeping Pills/Sedatives ___ | Cocaine/Crack ___ | Alcohol___ |
| Tranquilizers/Valium ___ | PCP ___ | Other___ |

34. Have you ever experienced a serious head injury? Yes___ No___

35. If yes, were you unconscious? Yes___ No___

36. Have you ever experienced a seizure? Yes___ No___

37. Do you have any serious medical conditions or concerns at this time? Yes___ No___

38. If yes, describe briefly: _____
_____
_____
_____

39. Check any of the following which you have experienced during the last 2 weeks:

| | |
|---|---|
| Nervousness/Tension/Anxiety___ | Relationship Problems___ |
| Depression___ | Loss of Appetite___ |
| Sleeping Problems___ | Feeling Hopeless___ |
| Memory Problems___ | Concentration Problems___ |
| Dizziness___ | Severe Headaches___ |
| Racing Thoughts___ | Hallucinations___ |

Other___, Describe:_____
_____
_____

40. Do you desire psychological services at this time? Yes___ No___

41. Signature_____ Date_____

# CHAPTER 5

# SPECIAL INMATE PROGRAMS

## 5.1 DRUG ABUSE PROGRAM

Although the types and numbers of drug treatment programs offered and the program models used have varied over the years, the Bureau has provided drug treatment programs for inmates since the 1960s. The Bureau's current drug treatment strategy was developed in 1989 and offers, through Psychology Services, a number of different drug-related treatment services to those inmates identified and assessed as drug dependent. These treatment services are summarized below. More detailed information about the Bureau's Drug Treatment Programs can be found in the most recent BOP directive on "Drug Abuse Program, Inmate" (5330).

### A. ADMISSIONS AND ORIENTATION SCREENING

The gateway to any of Psychology Services' Drug Treatment Programs is through the Admissions and Orientation (A & O) process as the inmate enters the institution. During A & O, the inmate is informed of the drug programs available in the institution and is screened for a history of drug abuse. This screening includes a clinical evaluation of the inmate's substance abuse history and related problems, as well as a review of objective file data to determine whether any of the following are true for an individual inmate:

(1) there is evidence in the Pre-Sentence Investigation Report that alcohol or other drug use contributed to the commission of the instant offense;

(2) alcohol or drug use was the reason for a violation of probation, parole, or supervised release for which the inmate is now incarcerated; or

(3) the inmate was recommended for drug treatment during incarceration by the sentencing Judge.

### B. DRUG EDUCATION

A standardized Drug Education course is offered at all institutions with sentenced populations. The course is mandatory for inmates who meet one of the three criteria listed above. Those inmates must complete the course within the first twelve months of incarceration. Sanctions, such as restriction to the lowest inmate pay grade, are imposed on those inmates who do not complete the course or who refuse to complete the course.

All other inmates may apply to take the course at any time on a voluntary basis. In addition, Psychology Services or Unit Team staff should recommend the course for inmates who have a history of substance abuse problems but do not meet any of the three criteria listed above.

## C. NON-RESIDENTIAL DRUG TREATMENT

Every institution's Psychology Services Department will provide non-residential drug treatment services. Non-residential treatment services will be available to any inmate with either a primary or secondary diagnosis of substance abuse. Treatment services will begin with an assessment of the individual's treatment needs followed by the development of a treatment plan. Specific treatment needs will be addressed through individual and/or group counseling. Support groups such as AA or NA may be used as an adjunct to non-residential treatment, but are not, in and of themselves, considered treatment. Inmates with a diagnosis of substance abuse may either apply to or be recommended for non-residential treatment at any time during their incarceration. For those inmates who desire or are recommended for residential treatment, but who have less than sufficient time left to serve or are otherwise ineligible, non-residential treatment may be recommended as an alternative.

## D. RESIDENTIAL DRUG TREATMENT

Residential treatment is provided at selected institutions. Inmates who participate in residential programs are in treatment approximately 20 hours per week (i.e., four hours per day - 5 days per week) and reside on a unit with other program participants. Treatment for each inmate is guided by an individualized treatment plan developed through an extensive psychological/behavioral assessment. All participants are exposed to three program phases which span approximately 12 months and which include the following core elements:

(1) Phase One -- Orientation and Introduction to the Residential Treatment Program.

(2) Phase Two -- Intensive Treatment and Skill Development. The following core skill elements will be covered during this phase:

(a) Cognitive Skills Training;
(b) Communication and Interpersonal Skills Training;
(c) Criminal Lifestyle Confrontation Programming;
(d) Wellness Training;
(e) Relapse Prevention; and
(f) Individual and Group Psychotherapy.

(3) Phase Three -- Pre-Release Planning

Currently, there are 30 Residential Drug Treatment Programs. One of these 30 programs specializes in the treatment of Cuban detainees. In addition to these 30 programs, there is one Intensive Outpatient Program which meets all the treatment and staffing requirements of the Residential Treatment Programs without requiring participants to reside in the same housing unit. The list below indicates the institutions where intensive drug treatment programs are located. The Cuban Drug Program is marked by an asterisk and the Intensive Outpatient Program is marked by a double asterisk.

| NORTHEAST | MID-ATLANTIC | SOUTHEAST |
|---|---|---|
| FCI Fairton | FMC Lexington | FCI Tallahassee |
| FCI Danbury | FCI Butner | FCI Marianna |
| FPC Allenwood | FPC Alderson | USP Atlanta |
| FCI McKean | FCI Morgantown | FCI Talladega |
| | USP Terre Haute | |

| NORTH CENTRAL | SOUTH CENTRAL | WESTERN |
|---|---|---|
| FCI Oxford | FCI Seagoville | FCI Sheridan |
| FMC Rochester | FCI El Reno | FCI Phoenix |
| FCI Englewood* | FCI Three Rivers | FCI Dublin |
| USP Leavenworth | FCI Fort Worth** | USP Lompoc |
| FPC Yankton | FCI La Tuna | FCI Lompoc |
| | FPC Bryan | FCI Terminal Is. |
| | FCI Bastrop | |

## E. TRANSITIONAL SERVICES

All institutions will provide continuing drug treatment to inmates who complete residential treatment programs and who are not immediately released to the community. Treatment gains are more likely to be maintained if inmates continue to be engaged in treatment upon completion of a residential program. Such treatment can be accomplished through, but is not limited to, non-residential drug treatment programs at all institutions.

In order to maximize treatment gains and the successful reintegration of the inmate into the community, transitional/aftercare services will be provided to all inmates who successfully complete a BOP drug treatment program upon their release. The Bureau of Prisons will contract with providers in the community to accomplish this. Inmates who successfully complete a residential drug treatment program will be required to participate in transitional services as part of their basic drug treatment program contract. For inmates who have successfully complete a non-residential drug treatment program transitional services are optional. Inmates from non-residential programs may be referred for transitional services based on the judgement and recommendation of their DAP psychologist. Institution drug treatment and unit staff are responsible for providing Regional Community Corrections staff with relevant information on those inmates being released to the community. Bureau staff will work closely with community providers and U.S. Probation Officers, so that continuity of care is insured.

## 5.2 SEX OFFENDER TREATMENT PROGRAM

The Sex Offender Treatment Program (SOTP) is a residential treatment program located at the Federal Correctional Institution in Butner, North Carolina. Psychology staff, as part of the initial inmate psychology intake screening process, are charged with identifying potential SOTP participants. Those identified inmates who meet the below referral criteria may be considered for referral to the SOTP where they will be provided with the tools needed to gain control of their sexual deviancy and develop methods which will help prevent relapse and further victimization of members of society.

### A. PROGRAM REFERRAL CRITERIA

In reviewing candidates for the SOTP, psychology staff should insure that the following general criteria are met:

(1) inmate has a documented history of sexual deviancy. It is not required that the inmate currently be serving an incarceration for a sex offense.

(2) inmate has a maximum of twenty-four months and a minimum of twelve months remaining on his current Federal incarceration.

(3) inmate has no pending detainers. Program involvement requires the SOTP to be able to arrange follow-up, outpatient treatment after parole. Detainers preclude this from happening.

(4) inmate has no history of recent psychotic episode(s).

(5) inmate is literate.

When an inmate is assessed by staff to be an appropriate candidate for the SOTP, the psychologist making this determination will meet with the inmate and discuss the possibility of referral to the SOTP. Staff may not mandate participation in this program.

Inmates who possess long criminal records for non-sex offenses will have their referral packets closely scrutinized to ensure that they are not seeking admission to the SOTP for nontherapeutic reasons.

**B. REFERRAL PROCEDURES**

A referral package must be submitted by the sending institution's Warden to the Warden of FCI Butner. This referral package must include a copy of the Pre-Sentence Investigation Report, a copy of the most recent case manager's progress report, and a memo from a member of the Psychology Department at the sending institution indicating why that psychologist feels the inmate is an appropriate candidate. In addition to completing and sending this package, a staff psychologist at the sending institution should have the inmate candidate read the SOTP's criteria for admission and program description statement and reach an understanding that they will have to participate in all phases of the program to achieve successful completion. Staff are to notify the candidate that inmates who opt out of or are dismissed from the program will be promptly returned to the institution that made the referral.

**C. PROGRAM DESCRIPTION**

When an inmate arrives at the SOTP, he will be placed in program candidacy status for a period of sixty days. During this time period, the inmate will complete a battery of tests and participate in group and individual therapy sessions. The focus of these sessions will be on assessing the nature of the inmate's sexual deviancy and on examining the inmate's amenability to treatment. At the end of the sixty day assessment period, a decision will be made by SOTP staff as to whether the inmate should continue on with the remaining program components.

The majority of the program's therapy components are completed in a group psychotherapy setting. The group components focus on specific issues and run for periods of three to six months with weekly meetings. Each inmate must complete the following group components for full program completion:

(1) Victim Empathy;
(2) Behavior Therapy for Sexual Arousal Disorders;
(3) Anger Management;
(4) Social Skills;
(5) Cognitive Distortions;
(6) Personal Victimization;
(7) Sex Education; and
(8) Relapse Prevention.

A group focusing on substance abuse is also available for inmates with this history. Finally, each inmate participant is assigned a primary therapist who also conducts one individual session per week with the inmate.

## 5.3 SUICIDE PREVENTION PROGRAM

The Bureau of Prisons is strongly committed to the deterrence and prevention of inmate suicide. In most institutions the Chief Psychologist serves as the Suicide Prevention Program Coordinator. All other psychology staff also play an active role in the implementation of the Suicide Prevention Program. The Program has four basic components.

### A. TRAINING

All institution staff are trained to recognize signs and symptoms of suicide potential, the appropriate procedures to follow when referring an inmate for evaluation, and suicide prevention techniques. This training is the responsibility of the Chief Psychologist and ordinarily occurs during Institution Familiarization and Annual Refresher Training. Supplemental training on suicide prevention should also be provided to the following staff on a bi-annual basis: physician's assistants, correctional counselors, and lieutenants.

### B. IDENTIFICATION

All newly admitted inmates are screened routinely by a physician's assistant within 24 hours of their arrival at the institution for signs of potential suicide. Also, assessment of suicide potential is a routine component of all initial psychological screenings conducted by psychologists.

**C. REFERRAL**

Inmates identified as potentially suicidal during the screening process are referred to the Program Coordinator by the PA. Inmates may also be referred to the Program Coordinator or any other psychologist by any staff member who observes any indicator of suicidal behavior.

**D. ASSESSMENT AND INTERVENTION**

All inmates referred to the Psychology Department through this Program will be assessed for suicide potential. Those inmates who are judged to be suicidal will receive appropriate follow-up treatment.

The Program Statement on the Suicide Prevention Program is referenced for more detailed information regarding specific program requirements.

**5.4 HIV+/AIDS COUNSELING PROGRAM**

The Bureau has attempted to slow the spread of AIDS within the inmate population by developing an active education and counseling program aimed at increasing inmate awareness regarding high risk behaviors and methods of viral transmission. While the AIDS Education/Counseling Program is the responsibility of the Health Services Department, Bureau policy dictates that inmates who test positive for the AIDS virus be referred to Psychology Services for follow-up. It is essential that a procedure be in place which will allow for an open system of communication and referral between the Clinical Director for Health Programs and the Psychology Department. It is incumbent on the Chief Psychologist to develop and implement a procedure for this flow of essential patient information.

The Program Statement on Human Immunodeficiency Virus is referenced for more detailed information on the Bureau's HIV+/AIDS education and counseling program.

* **5.5 LIVING FREE PROGRAM**

The Living Free Program is designed to assist inmates to develop a more socially acceptable lifestyle through a review of their values. The intent of the program is to help inmates begin a process of self-assessment, examine their life options, and develop a plan for personal change aimed at enhancing honesty, respect, tolerance, and responsibility. The program is

conceptualized as a "gateway" program-encouraging participation in other institution self-development programs. The program is neither designed nor intended to undo a lifelong pattern of criminality.

The objective is to begin the process of change and involve the participant at the cognitive, emotive, and behavioral levels. Program participation is voluntary.

**A. PROGRAM DESCRIPTION AND OVERVIEW**

In 1993, the Living Free Program was piloted at seven institutions. Results indicated that it generated very positive responses from both participants and the trainers who facilitated the program. Information obtained from the seven pilots was used to further refine the program. The program has seven goals for the inmate participants:

(1) review their lifestyle with a focus on the costs of criminality;

(2) review the values reflected in a criminal and dysfunctional lifestyle;

(3) understand how specific patterns of thinking support values;

(4) gain an understanding of the process inherent in changing values and habitual patterns of behavior;

(5) learn how choices of activities and associates influence positive and negative behavior;

(6) gain an appreciation of the role that family and community play in their lives;

(7) as a result of the previous insights, develop a specific plan for lifestyle change.

Each goal is accomplished in a two to three hour structured group session. The facilitator concludes the program in an individual session with each participant, providing feedback relative to both the inmates' participation and, very importantly, to the plan for change each participant is required to develop. Group exercises, discussions, homework assignments, handouts, presentations, and videotapes were selected for the program because of their demonstrated impact on participants. All materials developed for their program are available or can be obtained through the Regional Psychology Administrators.

**B. INSTITUTION IMPLEMENTATION**

Four facilitator/trainers from each region received the necessary knowledge and skills to successfully facilitate the Living Free Program at a "trainers for trainers" program, conducted at the Management and Specialty Training Center. Each region is responsible for developing a strategic plan to train staff and implement the program in all institutions. It is expected that the program will be offered at least once a year. Normally, a Psychology Services staff member shall coordinate the institution program.

**C. REGIONAL PSYCHOLOGY ADMINISTRATOR**

Regional Psychology Administrators are to monitor the progress of the Values Development Program at all institutions in their regions. An Annual Report shall be provided to the Central Office Psychology Services Administrator, by the end of each calendar year. At a minimum, it should provide information on the number of participants (by institution) completing the program. As other program evaluation information is developed it will also be included as part of the annual report.

**D. CENTRAL OFFICE PSYCHOLOGY ADMINISTRATOR**

Within 30 days of receiving the regional reports, a system-wide report will be provided to the Assistant Director, Correctional Programs Division, summarizing the status of the program for the reporting year. *

# CHAPTER 6

# PSYCHOLOGY PROGRAMS FOR BUREAU STAFF

The Bureau of Prisons encourages psychologists to apply their specialized knowledge and expertise not only to the mental health needs of inmates, but also to the unique problems and challenges of correctional workers. Psychologists are typically involved in a number of institutional activities aimed at enhancing the knowledge, professionalism, and well-being of staff.

## 6.1 EMPLOYEE ASSISTANCE PROGRAM

The Bureau of Prisons recognizes that substance abuse or emotional difficulties are serious problems which can adversely affect an employee's personal well-being as well as job performance. The Employee Assistance Program (EAP) is a Psychology Services program designed to aid staff in overcoming emotional difficulties or substance abuse problems which are adversely affecting their job performance.

Staff may become involved in the EAP either through self-referral or a referral from a supervisor. When the staff member independently seek EAP services, these services are confidential in nature, unless the issues presented involve a clear and imminent danger to self or others or child abuse is suspected. When the staff member is referred by a supervisor, the EAP counselor will be expected to tell the supervisor whether or not the employee made contact for EAP services. This is the only information which can be revealed, unless the employee signs a release of information form. An employee can never be ordered to participate in EAP services and, therefore, can never be disciplined for not following through on a supervisor's recommendation to see an EAP provider.

The Chief Psychologist serves as the Employee Assistance Program Coordinator at the institution. As the EAP Coordinator, the Chief Psychologist not only provides EAP counseling services, but also has administrative responsibility for the program. Specifically, he or she collects data on program utilization and develops and monitors local contracts for outside EAP services. Any psychologist designated by the Chief Psychologist may serve as an EAP Counselor.

Services to staff and their families (when feasible and clearly related to the staff member's difficulties) include the following:

**A. ASSESSMENT**

The psychologist evaluates the employee's presenting problem and suggests possible solutions and/or strategies for management of the problem. Employees who suspect that they may have an alcohol, drug, or emotional problem which is having an adverse effect on their job performance are encouraged to voluntarily seek assistance from an EAP counselor.

**B. REFERRAL**

The psychologist provides the employee with information about outside providers who are qualified to help with the type of problem which has been assessed. The psychologist also tries to match cost of the service with the employee's ability to pay through health or other available benefits.

**C. FOLLOW-UP**

The psychologist monitors the employee's participation in the plan which has been developed and assists in the coordination of the employee's re-entry to the job situation when treatment has involved time away from the work site.

**D. SHORT-TERM OR CRISIS COUNSELING**

The psychologist, in some instances, may be the provider of counseling services to the employee. The psychologist makes the decision to treat the employee or to refer to an outside treatment provider based on his or her time constraints and qualifications (e.g., financial problems may be better handled by a consumer credit counseling service). Generally, employee problems requiring more than three or four counseling sessions to address should be referred to an outside treatment provider.

**E. EDUCATION**

The psychologist provides education about EAP and the types of problems employees often encounter. Education may help individuals self-identify as needing services and encourage employees to seek help early in the development of problems. Education should also assist supervisors in identifying, managing, and referring troubled employees to the Employee Assistance Program.

Education might be viewed as the "preventive" portion of the Employee Assistance Program. Psychology staff have developed a number of innovative psychoeducational programs to assist staff and interested family members in improving their general

resiliency to stress. Examples of such programs include, but are not necessarily limited to, the following:

(1) stress management training
(2) smoking cessation
(3) behavioral aspects of weight management
(4) effective parenting techniques
(5) drug education/awareness
(6) anger management
(7) retirement planning

Assessment, referral, and counseling services provided through the EAP are strictly confidential, except where otherwise specified by federal and/or relevant state statutes. Specific guidelines for the Employee Assistance Program, including those related to confidentiality, are more clearly defined in the Bureau's Program Statement on the Employee Assistance Program (EAP).

## 6.2 STAFF TRAINING ACTIVITIES

Psychologists are encouraged to share their expertise on mental health issues with interested staff through staff training activities. Staff training activities conducted by psychologists are ordinarily either requested by or arranged through the institution's Employee Development Manager and emphasize assisting staff in performing their job with more insight, skill, and professionalism or focus on ways staff can improve their sense of personal well-being.

Psychology staff are typically involved in the following types of training:

### A. INSTITUTION FAMILIARIZATION TRAINING

Psychology staff are routinely asked by institutional Employee Development staff to provide relevant training to new employees during Institution Familiarization Training. The curriculum for this training has been developed by Employee Development staff so that it will dovetail with the Introduction to Correctional Techniques program offered at the Staff Training Academy in Glynco, Georgia. Ordinarily during Institution Familiarization Training, Psychology staff are asked to acquaint new staff with Psychology Services programs and operations. Typically, Psychologists are asked to instruct new employees in how to recognize and manage mentally ill individuals (especially those with suicide potential) and how to make good referrals to Psychology Services. New employees are also ordinarily briefed by Psychology staff on the EAP and its psychoeducational programs.

## B. ANNUAL REFRESHER TRAINING

The core curriculum for Annual Refresher Training is developed each year by the Central Office Human Resource Division's Training Branch with input from the field and is then submitted to the Bureau's Executive Staff for approval. Typically, Psychologists are involved in presenting material related to the Suicide Prevention Program and the Employee Assistance Program which are included as part of this core curriculum. While not required, psychology staff are encouraged to suggest, through their institution's Employee Development Manager, other mental health program ideas which they believe might be of interest and benefit to staff during Annual Refresher Training.

## C. CORRECTIONAL COUNSELOR TRAINING

With appropriate training, Correctional Counselors can often serve as adjunct treatment staff within the institution. Because of their daily contact with the inmates assigned to their units, correctional counselors are often effective at identifying inmate adjustment problems and at assisting inmates in dealing with these problems. Psychology staff can assist correctional counselors in these activities by offering them periodic training in counseling techniques. In planning counselor training, past experience has shown that counselors benefit most from training which stresses "hands on" experiences and practice rather than didactic instruction. The Psychologist's training role with Correctional Counselor's is defined in the Bureau's Program Statement entitled "Correctional Counselor Training and Reference Guide".

## D. SPECIALTY TRAINING

Psychology staff are encouraged to periodically offer training to institution staff on psychological topics relevant to institutional needs. Specialty training should aid staff in better performing their institutional duties or increase their sensitivity on relevant correctional issues. Examples of specialty training may include, but are not necessarily limited to, the following:

(1) drug education/awareness training
(2) interpersonal skills training
(3) communication skills training
(4) hostage negotiation training
(5) supervisory skills training
(6) training in the management of mentally ill inmates

(7) training in the use of inmate classification systems such as the Quay or Megargee Classification Systems
(8) effective leadership/management seminars
(9) training regarding special needs offenders

Any specialty training offered by Psychology staff should be coordinated through the institution's Employee Development Manager.

## 6.3 PRE-EMPLOYMENT SCREENING PROCESS

All applicants to the Bureau of Prisons are screened in several areas prior to a final decision regarding employment. Applicants are medically screened to insure that they will meet the physical demands of the job and that they are not involved in illicit drug use.

Applicant histories are reviewed through the Integrity Interview process to verify the presence of a stable, responsible, law abiding lifestyle and to establish a general character profile of the applicant. Integrity Interviews are ordinarily conducted by members of the Human Resource Department.

All applicants are also interviewed by a panel of experienced Bureau staff prior to a final decision to employ. This interview panel is composed of an Associate Warden, the Chief or Staff Psychologist, and the head of the department to which the applicant is applying. If a psychologist is unavailable to serve on the interview panel, Human Resources policy allows the use of any staff member with demonstrated interview skills (e.g., case management specialist). Service delivery priorities as outlined in Chapter 1 should be considered in determining psychologist availability.

The primary goals of the panel interview are to assess an applicant's oral and written communication skills, problem solving and decision making capacities, ability to supervise inmates and work effectively with other staff, and susceptibility to manipulation and corruption. Panel members base their assessments on an evaluation of the applicant's responses to relevant questions and situations presented during the interview, available employment history data, and written materials submitted by the applicant. While participating in the panel interview process, psychologists should conduct themselves in an ethically and legally defensible manner, should model appropriate interview behavior for other panel members, should use their unique skills and clinical judgment in arriving at a fair assessment, and should be aware of the limits of predicting job fitness.

Procedures defining the pre-employment interview process for prospective Bureau employees are outlined in more detail in the Bureau's Personnel Manual.

# CHAPTER 7

# PSYCHOLOGY PREDOCTORAL INTERNSHIP, POSTDOCTORAL RESIDENCY, AND CONTINUING EDUCATION PROGRAMS

## 7.1 INTRODUCTION

The Bureau of Prisons offers a variety of training opportunities for psychology graduate students as well as for its doctoral level psychologists. These training opportunities are provided through Psychology Services' Predoctoral Internship Program, Postdoctoral Residency Program, and Continuing Education Sponsorship and Training Program. Each of these programs strives to meet those training standards established by the American Psychological Association (or other accrediting bodies) and provides quality training to its participants.

## 7.2 PREDOCTORAL INTERNSHIP PROGRAM

The primary purpose of the Predoctoral Internship Program is to provide a high quality training experience for clinical and counseling psychology graduate students who are in their last year of academic training. The Predoctoral Internship Program is designed to provide a well-rounded training experience leading to the production of a clinical generalist. The secondary purpose of the Predoctoral Internship Program is to assist the Bureau of Prisons in its recruitment of well trained and knowledgeable psychologists who have received training in the uniqueness of professional clinical practice in correctional settings. All Bureau Predoctoral Internship Programs shall meet psychology training standards established by the American Psychological Association (APA) and actively pursue and/or maintain APA accreditation.

### A. ADMINISTRATION

The Central Office Clinical Programs Coordinator is responsible for the overall management of the Psychology Internship Program. The Clinical Programs Coordinator in consultation with Regional and institutional administrative and psychology staff determines the selection of internship sites and the placement of internship positions. The Director of Clinical Training (DOCT) at each facility with a Predoctoral Internship Program is primarily responsible for intern recruitment and selection, as well as the formulation and administration of the training curriculum at his or her particular institution.

## B. PROFESSIONAL STANDARDS

Standards for the predoctoral internship program are based on accreditation criteria for internship programs used by the APA, membership criteria and by-laws of the Association of Psychology Postdoctoral and Internship Centers (APPIC), and on standards developed by a committee comprised of BOP Central and Regional Office Psychology Administrators and Directors of Clinical Training from several internship sites.

## C. STANDARDS FOR THE ASSIGNMENT OF INTERNSHIP SITES

In assigning interns to training sites, the Central Office Clinical Programs Coordinator and Regional Psychology Administrators will be guided by the training site's ability to comply with the following standards (in order of priority):

(1) APA approved internship program, either direct or in consortium arrangement.

(2) Quality of training and supervision. This factor will be assessed through an evaluation of the number of psychology staff, licensure or other professional certification status (e.g. ABPP) of staff, combined clinical and correctional work experience of staff (five years minimum required), evaluation of the training site by the student-intern's university, the evaluation of the training site by the intern, and the availability of community resources which are necessary adjuncts to such a training program (e.g., universities, cooperating mental health agencies, etc.).

(3) Recruitment history (i.e. how many interns have been successfully recruited as full-time psychologists over the past three years);

(4) Physical plant of the Psychology Department (i.e., a centralized department with adequate space to provide each intern with an individual office and sufficient treatment space).

(5) Evaluation and support of the training program/site by institution and regional administrators (e.g. Warden, Associate Warden, Regional Psychologist, etc.);

(6) Type of inmate population (i.e. breadth of training opportunities and inmate types).

Those institutions wishing to participate in the Internship Program can do so by having the Chief Psychologist apply for intern(s) placement at their respective institution by submitting a written proposal to the Central Office Clinical Programs Coordinator. The proposal should have the approval of the Warden and the Regional Psychology Administrator prior to submission to the Central Office. Attachment 7-A provides the required format for proposal submissions. Proposals should be sure to address each of the above standards in detail.

## D. RECRUITMENT/APPLICATION PROCEDURES FOR THE PSYCHOLOGY INTERNSHIP PROGRAM

Although the Central Office Clinical Programs Coordinator has overall responsibility for management of the internship program, the responsibility for recruiting competent applicants is shared by all DOCTs, Chief Psychologists, and Regional Psychologists. In attempting to recruit interns, the following guidelines/procedures should be followed:

(1) Personal contacts with universities and professional schools should be utilized to encourage intern applicants.
(2) An announcement of the Internship Program should be carried each year in the APPIC Directory. All sites with internship programs should be members of APPIC.

(3) An announcement of the Internship Program may be placed in the APA Monitor during the Fall and early Winter issues. Placement of this announcement in the APA Monitor will be the responsibility of the individual training site.

(4) Interested applicants must complete a standard Office of Personnel Management Application (SF 171), and send it along with a transcript of graduate school work and three letters of recommendation to the Director of Clinical Training at the institution(s) to which they wish to be considered no later than January 4th of the year during which the intern wishes to be placed.

(5) All intern applicants are encouraged to complete an on-site interview prior to January 4th at the internship site where they are applying. If this is not feasible, they are required to complete a telephone interview at this institution.

(6) In accordance with APPIC rules, applicants cannot be notified of their selection prior to the second Monday in February of the placement year.

(7) All selected interns are required to complete a pre-employment interview (including finger printing, NCIC check, urinalysis, and physical examination) at the nearest BOP institution, prior to beginning their training. **Offers of internship positions made in February are considered tentative until all pre-employment personnel procedures are successfully completed and until funding for the program is actually allotted by Congress. This information should be clearly conveyed to all intern applicants in any written correspondence.**

(8) Interns will ordinarily begin their BOP Psychology Internship on Monday of the first pay period in October and are expected to complete 2000 hours of training. Interns wishing to begin their training year on an earlier date must make these arrangements through the Director of Clinical Training at the individual training site.

**E. SELECTION CRITERIA**

The following criteria will be used when selecting predoctoral internship candidates:

(1) Internship candidates must be matriculating in a regionally accredited psychology program in Clinical or Counseling Psychology.

(2) Internship candidates must be in good standing in their doctoral program and be approximately one year from completion of all degree requirements.

(3) Internship candidates must meet all criteria for employment in the Bureau of Prisons.

(4) APPIC guidelines regarding internship offers and acceptances must be followed.

(5) Applicants from APA-accredited programs in Clinical and Counseling Psychology will be given preference in the selection process.

## F. CONTENT OF THE INTERNSHIP

The primary goal of the Psychology Internship Program is the training of professional psychologists. The position description found in Attachment 7-B outlines standard duties typically assigned to interns. The psychology staff at each institution should develop a means of assessing each intern's competence and provide training for all core curriculum items listed in Attachment 7-C. These core curriculum items were originally developed by the BOP's DOCTs and are reviewed and updated periodically by this group. Core curriculum items are meant to establish a minimum training agenda for internship sites. Internship sites are encouraged to exceed these minimum standards, wherever and whenever possible.

## G. SUPERVISION AND EVALUATION OF INTERNS

A licensed psychologist will have overall responsibility for the supervision of the psychology interns. This individual is designated the DOCT. At a minimum, the DOCT must hold current licensure in the state in which he or she is practicing. The staff member who serves as DOCT can be expected to devote a minimum of 50 percent of his or her time to activities directly related to the internship program. The intern's clinical supervisor is responsible for ensuring the following supervision requirements:

(1) The clinical supervisor will meet with the intern and jointly review course work and job experiences and plan a training program that best meets the training needs of the intern. This will include a one day per week outplacement, to be served at a local cooperating mental health agency, where the intern will be supervised by a licensed psychologist.

(2) A minimum of three hours per week of regularly scheduled, formal, face-to-face individual supervision will be provided to each intern. Supervision will review direct psychological services rendered by the intern. One hour of this supervision can come from the intern's outplacement. Two hours of group supervision can also suffice for one of these hours.

(3) Completion of the Psychology Intern Evaluation Form (Attachment 7-D) quarterly. These evaluative reports will be discussed with the intern and initialed by the intern. The intern will receive the original and a copy will be sent to the intern's university. The Director of Clinical Training should retain one copy in a local file.

**H. PLACEMENT EVALUATION BY INTERNS**

Each intern is required to complete the Internship Evaluation Form (Attachment 7-E) quarterly. This will be used to determine what changes might be made in the intern's training experience in order to enhance the quality of the remainder of his or her internship. A copy is to be maintained by the DOCT.

**I. DISSERTATION RESEARCH**

Every effort should be made to encourage completion of dissertation research for the intern's doctoral degree. The more progress the intern makes on the dissertation during the internship year, the closer the intern will come to meeting the qualifications for full-time employment. While the number of hours allotted for this activity will vary with each intern's chosen research topic, state of development, etc., four to eight hours per week is considered appropriate. It is incumbent upon the Chief Psychologist and DOCT to closely monitor this activity and structure the intern's training year to encourage completion of the dissertation by the conclusion of the internship year.

**J. FUNDING FOR PSYCHOLOGY INTERNSHIP PROGRAMS**

Internship Programs are funded through Cost Center 316. Funding is provided for such activities as:

(1) consultants to provide training experiences for interns.

(2) meeting expenses incurred by interns during their internship year.

(3) application fees and membership dues in APPIC.

(4) fees related to getting and maintaining APA accreditation.

## 7.3 POSTDOCTORAL RESIDENCY PROGRAM

The Psychology Services Postdoctoral Residency Program is a one year training opportunity for doctoral level psychologists who are interested in a correctional setting. The Postdoctoral Residency Program may be used in one of several ways. It may be used to provide doctoral level psychologists with an opportunity to receive general clinical training in all facets of

correctional psychology. It may also be used to expose doctoral level psychologists to clinical training in one of the several specialty areas typically found in correctional settings (e.g., drug abuse treatment, sex offender treatment, forensic assessment, etc.). The Postdoctoral Residency Program may also be used to provide the Bureau with a trained pool of applicants to fill staff psychologist vacancies.

## A. ADMINISTRATION

The Central Office Clinical Programs Coordinator is responsible for the overall management of the Postdoctoral Residency Program. The selection of Residency training sites and the placement of Residency positions within each Region will be made in consultation with Regional and institutional administrative and psychology staff. The DOCT at each institution with a Postdoctoral Residency Program, or where no DOCT exists, a senior clinician designated by the Chief Psychologist is primarily responsible for the recruitment and selection of residents, as well as the formulation and administration of the training curriculum at his or her particular institution.

## B. PROFESSIONAL STANDARDS

APPIC has established the following standards for Postdoctoral Residency Programs. Wherever and whenever possible, sites with postdoctoral residents are encouraged to meet these standards.

(1) A postdoctoral training program is an organized experience which, in contrast to on-the-job training, is designed to provide the Resident with a planned, programmed sequence of supervised training experiences. The primary focus and purpose is advanced training in some area or areas of professional psychology.

(2) The postdoctoral program has a clearly designated staff psychologist who is responsible for the training program's integrity and quality and who is either currently licensed/certified by the State Board of Examiners in Psychology in the state in which the program exists or who possesses advanced credentialing from the American Board of Professional Psychology in their area of specialization.

(3) The sponsoring institution has two or more psychologists on the staff as supervisors, at least one of whom is currently licensed/certified as a psychologist by the State Board of Examiners in Psychology in the state in which the program exists.

(4) Clinical supervision is provided by a staff member of the sponsoring institution who carries clinical responsibility for the cases being supervised. At least half of the clinical supervision is provided by one or more licensed/certified psychologists.

(5) At least 25 percent of the Resident's time is spent in direct patient contact.

(6) The postdoctoral residency program includes a minimum of two hours per week of regularly scheduled, face to face, individual supervision with the specific intent of dealing with psychological services rendered directly by the Resident. There must also be at least two additional hours per week in learning activities, such as: case conferences, involving cases in which the Resident is actively involved; seminars dealing with clinical issues; co-therapy with a staff person, including discussion; group supervision; additional individual supervision.

(7) Postdoctoral training follows completion of doctoral degree requirements and predoctoral internship meeting APPIC standards. APA guidelines on specialty change are followed. Residents having completed doctoral studies in fields other than clinical or counseling psychology have received a certificate of equivalency from an APA-approved university program attesting to their having met APA standards, including the internship.

(8) Postdoctoral trainees have a title, such as "Intern", "Resident", "Fellow" or other designation of trainee status.

(9) The sponsoring institution has a written statement or brochure which describes the goals and content of the program, states clear expectations regarding the Resident's work, and is made available to prospective Residents.

(10) The postdoctoral training program must be at least one-half time and last at least one year.

## C. STANDARDS FOR THE ASSIGNMENT OF RESIDENCY SITES

In assigning residents to training sites, the Central Office Clinical Programs Coordinator in consultation with the Regional Psychology Administrator will be guided by the training site's ability to comply with the APPIC guidelines specified above and to meet the same site standards (i.e., standards 2-6) established for predoctoral internship training sites.

Institutions wishing to participate in the Postdoctoral Residency Program can do so by having the Chief Psychologist apply for resident placement at their respective institution by submitting a written proposal to the Central Office Clinical Programs Coordinator. The proposal should have the approval of the Warden and the Regional Psychology Administrator prior to submission to the Central Office and should follow the format presented in Attachment 7-A.

## D. RECRUITMENT/APPLICATION PROCEDURES FOR THE PSYCHOLOGY POSTDOCTORAL RESIDENCY PROGRAM

Although the Central Office Clinical Programs Coordinator has overall responsibility for management of the residency program, the responsibility for recruiting competent applicants is shared by all clinical supervisors, Chief Psychologists, and Regional Psychologists. In attempting to recruit residents, the following guidelines/procedures should be followed:

(1) Personal contacts with universities, professional schools, community mental health facilities, and professional colleagues should be utilized to encourage resident applicants.

(2) An announcement of the Residency Program may becarried each year in the APPIC Directory for those institutions who are members of APPIC.

(3) An announcement of the Residency Program may be placed in the APA Monitor, other professional newsletters, or local newspapers. Placements of such announcements will be the responsibility of the individual training site.

(4) Interested applicants must complete, at a minimum, a standard SF 171 and send it along with an official transcript of their graduate school work and a geographic preference form to the Bureau's Special Examining Unit for Clinical or Counseling Psychologists in Washington, D.C. Other application material such as letters of recommendation, work samples, etc. may be requested from the individual training site.

(5) All resident applicants will be expected to complete the Bureau's standard pre-employment screening process before being formally offered a residency position.

(6) Residents may begin their training period anytime during the year and will ordinarily conclude their training one year from their starting date.

(7) Residents will be expected to successfully complete both institution familiarization training and the Bureau's three week Introduction to Correctional Techniques in Glynco, Georgia. Failure to successfully complete these programs will result in dismissal from the residency program.

(8) The Resident position is a career conditional appointment. However, Residents will be required to sign a mobility statement at the beginning of their residency year and may be required to move at the end of their training if they wish to continue their employment with the Bureau in a staff psychology position.

**E. SELECTION CRITERIA**

The following criteria will be used when selecting postdoctoral residency candidates:

(1) Residency candidates must have a Ph.D., Psy.D., or equivalent degree from a regionally accredited psychology program in clinical or counseling psychology.

(2) Residency candidates must meet all criteria for employment in the Bureau of Prisons.

(3) Applicants from APA-accredited programs in clinical or counseling psychology with APA-accredited internship placements will be given preference in the selection process.

**F. CONTENT OF THE RESIDENCY PROGRAM**

The primary goal of the Postdoctoral Residency Program is to train doctoral level psychologists in one or more clinical specialties. The position description found in Attachment 7-F outlines standard duties typically assigned to residents. The psychology staff at each institution should develop a written training agenda for each resident that specifies clinical duties, training opportunities, and supervision requirements.

## G. SUPERVISION AND EVALUATION OF RESIDENTS

A psychologist certified by the American Board of Professional Psychology and/or licensed in the state in which he or she is currently practicing will have overall responsibility for the supervision of the psychology resident. The resident's clinical supervisor is expected to devote a minimum of 25 percent of his or her time to activities directly related to the residency program. Additionally, the clinical supervisor will insure that the resident receives a level of supervision consistent with APPIC standards and that residents receive written evaluation of their performance quarterly. This evaluation should follow the general format presented in Attachment 7-D. The evaluation should be discussed with the resident and initialed by the resident. The resident should receive the original copy of the evaluation and the clinical supervisor should retain one copy in a local file.

## H. PLACEMENT EVALUATION BY RESIDENT

Each resident should have an opportunity to evaluate their training site quarterly. This evaluation should follow the general format presented in Attachment 7-E and should be used to determine what changes might be made in the resident's training experience to enhance the quality of the remainder of his or her residency. A copy of this evaluation should be maintained by the clinical supervisor.

## I. FUNDING FOR PSYCHOLOGY RESIDENCY PROGRAMS

Funds for the Residency Training Program are available through Cost Center 316. Funding is provided to cover such activities as:

(1) consultants to provide training experiences for the resident.

(2) meeting/outside training expenses incurred by theresident.

(3) application fees and membership dues in APPIC.

## 7.4 CONTINUING EDUCATION SPONSORSHIP PROGRAM

As technology and knowledge increase, innovative techniques for treating a wide range of disorders or specific symptoms are being developed. Bureau of Prisons' psychologists are expected, through ongoing professional reading and annual continuing education, to become aware of the latest approaches to therapeutic interventions and become skilled in the use of those techniques which would most benefit the inmate population.

The Bureau of Prisons through its Central Office Psychology Services Branch sponsors a number of educational programs for psychologists. These programs are primarily designed to meet the broad training needs of Bureau psychologists, to assist them in remaining current regarding innovations in the field of correctional psychology, and to facilitate high quality professional work among Bureau psychologists.

In order to allow Bureau psychologists to receive maximum benefit from participation in these programs, the Central Office's Psychology Services Branch has been approved by the APA as a sponsor of continuing education programs for psychologists. As an APA-approved sponsor of continuing education, the Central Office's Psychology Services Branch is able to grant APA-approved CE credit for programs which it sponsors.

### A. ADMINISTRATION

The Central Office Clinical Programs Coordinator is designated as the coordinator of the Psychology Services Continuing Education Sponsorship Program. As coordinator, the Clinical Programs Coordinator is responsible for insuring that all continuing education programs sponsored by the Bureau meet APA guidelines.

### B. PROFESSIONAL STANDARDS

Continuing education programs sponsored by the Bureau's Psychology Services Branch and granting APA-approved credit must conform to the following guidelines (excerpt from APA's Approval of Sponsors of Continuing Education for Psychologists: Criteria and Procedures Manual):

(1) CE programs for psychologists must be relevant to psychological practice, theory, or method at a postgraduate level.

(2) Facilities for CE activities must provide appropriate space for the kind of educational methodology used and be private enough to safeguard confidentiality of case material or work samples.

(3) CE programs for psychologists must have learning objectives which are expressed in behavioral terms with the specific outcomes expected of each objective stated clearly.

(4) CE programs for psychologists must be of sufficient duration to explore one subject or a closely related group of subjects in reasonable depth, but must not be less than one hour in length.

(5) A procedure must be in place that assesses each participant's satisfaction with the overall program and degree of perceived and/or actual achieved learning relative to the programs specific learning objectives.

(6) Instructional personnel must be competent and expert in the area to be taught and be able to facilitate learning. Teaching ability should be a primary prerequisite for selection as a CE instructor.

(7) Participants must be provided with documentation that states the number of CE credits earned. Credits must be awarded in units of whole or half-hours.

(8) Any demonstrations or procedures carried out by instructors and/or participants must conform to the highest ethical and professional standards as currently established by the APA's Ethical Principles of Psychologists and Code of Conduct.

(9) Participants are required to attend 100% of activities that are short term (up to one week) and 80% of activities that are long term (one week or longer) for credit to be granted.

(10) Participants must have access to the following information prior to enrolling in an activity offered for CE credit:

(a) the program's learning objectives;
(b) for whom the activity is designed and the skill level for which the activity is appropriate;
(c) program schedule and format;
(d) faculty credentials;
(e) the number of CE credits offered; and
(f) cost of the activity and refund/cancellation policy.

(11) A roster of CE participants and the number of CE credits awarded to participants must be kept by the sponsor for at least a five year period after the event.

### C. ACCESS TO CE SPONSORSHIP PROGRAM

The Central Office's Psychology Services Branch automatically grants continuing education credit to psychologists who participate in, and successfully complete, national continuing education programs for psychologists like orientation to correctional psychology, hostage negotiation training, and family and employee assistance team training, which are routinely offered by the Central Office's Psychology Services Branch. Additionally, CE credits may be awarded for portions of national meetings or conferences such as the Chief Psychologist's Conference which meet APA standards.

Chief Psychologists or Regional Psychologists who wish to conduct APA-approved CE programs which meet the above criteria should contact the Central Office Clinical Programs Coordinator who will assist in coordinating the program and who will maintain APA documentation.

## 7.5 CONTINUING PROFESSIONAL EDUCATION FOR PSYCHOLOGY STAFF

While the Bureau's Continuing Education Sponsorship Program allows the Central Office Psychology Services Branch to grant APA-approved CE credits for programs which benefit groups of BOP psychologists, the Bureau's Continuing Professional Education (CPE) Program for Psychology Staff offers each licensed BOP psychologist an opportunity to address individual continuing education needs. Through this program, individual psychologists are able to accumulate CE credits which are necessary in order to maintain professional licensure. This program also serves to enhance the recruitment and retention of career-oriented psychologists. Psychologists will be in training status while participating in CPE Program.

### A. ADMINISTRATION

The CPE Program is administered by the Central Office Psychology Administrator. As program coordinator, the Central Office Psychology Administrator is responsible for requesting a funding allocation annually for use by program participants and has final authority over all aspects of the program, including how funding is to be allotted each year.

(1) Once an amount has been set by the Central Office Psychology Administrator for each psychologist to use in meeting their individual CPE needs, costs in excess of this amount will become the responsibility of the individual psychologist.

(2) All funding for travel related to the CPE Program must meet Federal travel regulations.

(3) Funds set aside for the CPE Program must be used exclusively for this purpose.

**B. STAFF ROLES/RESPONSIBILITIES AND PROCEDURES**

(1) Each psychologist shall:

(a) identify CPE courses which are applicable to their particular specialty and which are documented in their Employee Development Plan.

(b) request authorization to attend courses at least 60 days prior to the start of the course.

(c) agree to supplement funds when funding allocations are not sufficient to meet all course related expenses.

(2) The institution Employee Development Manager shall:

(a) prepare and finalize the Training Course Authorization and Codes Form (SF-182). CPE courses do not require institution training committee approval unless they are funded (in whole or in part) by the institution.

(b) assist the psychology staff in travel preparation.

(c) input all training data into the Staff Training Data Systems.

(d) complete and transmit EMS Form 18 to the Regional Office Psychology Administrator (via SENTRY) with final cost estimates.

(3) Each Chief Psychologist shall:

(a) ensure that all training requests conform to each employee's professional development plan.

(b) obtain written approval from the Regional Psychology Administrator for each course request and maintain a copy of the request on file for review.

(4) The Regional Psychology Administrator shall:

(a) advise psychology staff of the availability of these CPE funds and the criteria governing their use.

(b) review and approve CPE course requests for compliance with established criteria.

(c) transmit approved EMS Form 18 (via SENTRY), with approval and dollar amount approved noted on form, to the Central Office Psychology Administrator.

# APPLICATION FOR CLINICAL PSYCHOLOGY TRAINEE POSITION

## I. PROPOSED PROGRAM

### A. Description of Training Experiences for Trainee Position

1. Specify those areas in which trainee(s) will receive supervised experience, indicating approximately the percentage of time that will be spent in each area (e.g., % time in psychological testing, diagnostic interviewing, crisis intervention, group therapy, etc.) Refer to specific criteria for internship programs in the American Psychological Association's Accreditation Handbook (1986) if application is for internship position.

2. List the opportunities for the trainee(s) to participate in ongoing research being conducted at your institution, including potential dissertation research areas.

### B. Supervision

1. Comment on your proposed program for supervision of psychology trainee(s). Provide as much detail as possible.

### C. Continuing Education Program

1. List consultants or plans for outside speakers in the past and upcoming year. Describe other arrangements for professional growth of staff and trainees. How often will didactic training be offered?

2. List skill areas to which the trainee(s) would be exposed, but for which there is currently no supervision available. Describe how supervision would be arranged for trainee(s) in each of these areas.

3. Describe special facilities that would be utilized in the training program (i.e., library, computers, special rooms, use and training in special instruments such as the Halstead-Reitan, etc.)

4. Do you involve outside consultants in your current program? If so, comment on the number of hours they spend at your institution each week, their exact duties, qualifications, etc.

5. Please comment on outside training experiences that will be available to the trainee(s). How much time is available to trainee(s) each month for training outside the institution?

**D. Affiliation with Other Agencies**

1. Would other agencies be involved in the training program? If so, describe agency and nature and extent of involvement. List and describe your proposed outplacement facility, if available.

2. Comment on the opportunities for the trainee(s) to use equipment from local universities.

3. Describe your affiliation with local universities (e.g., practica).

**E. Evaluation of Trainee(s)**

1. Describe criteria and means by which evaluations of trainee(s) will be made. Indicate how results will be communicated to trainee(s) and their graduate school, where appropriate. Refer to the Accreditation Handbook for internship program.

2. Describe criteria and means by which you will carry on an ongoing evaluation of your internship or residency program. Refer to the Accreditation Handbook for internship program.

**F. Facilities**

1. List types of equipment (e.g., typewriters, tape and video recorders, telephones, biofeedback, computers, etc.) that will be available to the trainee(s).

2. How much private office space will be reserved for the trainee(s)? Will each trainee have his or her own office? Describe space available for running groups, library, biofeedback, testing, etc. Comment on the adequacy of this arrangement.

## II. Personnel Support

### A. Staff Psychologists

1. Please include vita of all staff psychologists. Vitae should include exact graduate training (i.e., clinical, counseling, etc.); number of years with BOP, state prisons, or with criminal justice; years of related experience; and membership (fellow, officer, special honors) of professional associations such as APA, ACA, etc.

2. How many of your staff psychologists are licensed? How many are licensed in the state in which you are located now?

3. Please comment on the number of secretaries, clerks and support personnel that you have working in Psychology Services, the percentage of time each spends working for Psychology Services and include our opinion of the adequacy of this arrangement.

**POSITION DESCRIPTION**
Psychology Predoctoral Intern
GS-180-09

This position is located at_____. The Psychology Intern works under the close supervision of the Director of Clinical Training and/or other doctoral level psychologists employed by the Bureau of Prisons. The incumbent must be an advanced graduate student in a clinical or counseling psychology program and, where possible, a university program approved for training by the American Psychological Association. Initial selection is made by the Director of Clinical Training. Final responsibility for selection rests with the Bureau of Prison's Central Office Clinical Programs Coordinator.

At this level of training the incumbent's ability to provide services as well as to grow professionally are prime factors for evaluating the intern's effectiveness as a psychologist. The assignment is planned as a training position which provides intensive and continuous practical experience in the utilization of advanced techniques and procedures as they apply to the practice of psychology in correctional settings.

As a member of an interdisciplinary team with at least three hours/week supervision by doctoral level psychologists, the incumbent provides professional psychological services: diagnostics or assessments, therapy or treatment, research, and in-service training. The incumbent aids staff in formulating programs for inmates. The incumbent conducts and/or aids in staff training and consults with staff at all levels regarding treatment, training, and research. The incumbent keeps abreast of new trends and techniques, develops and improves professional skills, and maintains contact with the academic and professional community. The incumbent assists in administrative functions of the department.

**1. Knowledge Required by the Position**

A. Coursework in theories of personality, abnormal behavior, and psychopathology.

B. Coursework which covered the appropriate use, construction, theoretical rationale, and interpretation of assessment instruments in such areas as personality, intellectual functioning, neurological disorders, and vocational preference.

C. Coursework and/or practicum experience in clinical interview techniques, diagnostic and classification systems, and psycholgical report writing.

D. Coursework and/or experience in basic program evaluation and/or research methodologies and statistics.

E. Knowledge of ethical and professional aspects of a psychological services delivery system.

**2. Supervisory Controls**

A. In professional issues and decisions made by the incumbent, primary responsibility will rest with his or her immediate clinical supervisor.

B. For administrative and operational issues, the incumbent works under the general supervision of the Director of Clinical Training.

**3. Guidelines**

The incumbent conforms to ethical standards set forth by the American Psychological Association, by Federal Regulations, and by Bureau of Prison's policy.

**4. Complexity**

A. The incumbent provides professional psychological services to clients who represent a broad range of emotional, personality, mental, neurological, vocational, educational and social problems. Since many traditional therapeutic techniques have limited effectiveness with prison inmates, the incumbent must exercise ingenuity in adapting and extending existing methods or procedures in arriving at appropriate, innovative therapy techniques.

B. The incumbent provides consultation and training for institutional staff who vary widely in background, education, sophistication, and receptiveness to psychological principles. Therefore, ingenuity and creativity are required to adapt and extend the existing methods of teaching, training, and consultation.

**5. Scope and Effect**

A. Clinical recommendations and/or decisions have impact upon a large number of inmate clients.

B. Discovering effective techniques for working with inmate clients may represent significant extensions of existing theories and concept for psychology and corrections.

C. Psychological evaluations and/or recommendation have wide impact and influence which include the local institution, U.S. Parole Commission, and U.S. Courts.

D. Reseach, consultation, committee membership, and training activities have wide impact potentially affecting policies, procedures, programs and operations of the institution, the Bureau of Prisons, and correctional facilities in general.

**6. Personal Contacts**

Personal contacts are a continuing and vital part of the work. They include inmate clients, other psychologists, physicians and other medical staff, institutional staff at all levels, U.S. Parole Commission Examiners, Bureau of Prisons Regional and Central Office staff, and members of the professional and academic community.

**7. Purpose of Contacts**

Inmate patient contacts are for the purposes of observation, interview, treatment, and research. Contacts with institution staff are for the purposes of obtaining assessment information, discussing particular cases, sharing views on professional matters, devising and implementing appropriate treatment programs, and making recommendations and decisions for a variety of program and administrative dispositions. Thus the incumbent will contribute directly to the establishment of a positive treatment milieu such as will enhance the overall institutional rehabilitation program and the well being of clients.

**8. Physical Demands**

The work is generally sedentary. However, under emergency conditions the incumbent must be prepared to defend him or herself against assault by inmates.

**9. Work Environment**

The duties of this position require direct contact with individuals in confinement who are suspected or convicted of offenses against the criminal laws of the United States. Daily stress and exposure to potentially dangerous situations such as physical attack are an inherent part of this position.

# FEDERAL BUREAU OF PRISONS
# PSYCHOLOGY INTERNSHIP PROGRAM

## CORE CURRICULUM

INTRODUCTION

The Federal Bureau of Prison's Predoctoral Psychology Internship Program strives to meet the training needs of doctoral candidates in professional psychology through supervised experience with clinical populations found in a correctional setting, via didactic programs, and, where appropriate, by experiential training outside of the correctional milieu. The Predoctoral Internship Program offers a training experience that helps doctoral candidates make the transition from student to practitioner and is guided by the philosophy that clinical practice within a correctional setting requires the same core clinical skills and knowledge base as are found in any professional psychology practice.

The program's primary goal is to create well-rounded generalists in professional psychology. To accomplish this goal, the program stresses development of competence in such mainstream clinical skills as psychological assessment, intervention, consultation, and research. As a secondary goal, the program strives to impart to interns a core knowledge base about issues unique to the area of correctional psychology. To meet these stated program goals, all Bureau of Prison's Predoctoral Psychology Internship Programs which are APA-Approved guarantee training in each of the core content areas presented in this document.

This core curriculum statement was developed by the Directors of Clinical Training from the Bureau's current and planned APA-approved internship sites at their annual meeting on April 7-10, 1992. This document is intended to facilitate coherent program planning among the various sites while still allowing individual sites a high degree of flexibility to capitalize on their unique assets. As such, this core curriculum was developed to serve as a minimum set of experiences required to assure that a Bureau of Prison's Psychology Internship is a meaningful generalist training experience. In forming this core curriculum, reference was made to a number of published guidelines and recommendations regarding curriculum development for predoctoral internship training programs.

The Bureau of Prisons is committed to exposing interns to clinical work with diverse populations (in terms of socioeconomic status, ethnicity, and lifestyle) and presenting problems. Each APA-approved internship site will make every effort, within the parameters of its mission and resident population, to facilitate such broad exposure. To meet this objective interns may be exposed to clientele including inmates, correctional staff, and organizational consumers such as institutional management or the federal court system.

**CURRICULUM CONTENT AREAS**

## I. Assessment

**A. Objective 1:** Interns will be able to utilize a variety of approaches to diagnosis and assessment. Specific areas of assessment to be covered include:

1. Clinical Interviewing;

2. Clinical/Behavioral Observation; and

3. Psychological Testing such as:
   a. objective personality tests
   b. projective personality tests
   c. intelligence tests
   d. neuropsychological measures

**B. Objective 2:** Interns will be able to interpret data generated through assessment, develop appropriate formulations of this information, and prepare comprehensive written reports documenting assessment results.

## II. Intervention

**A. Objective 1:** Interns will have experience with the planning and implementation of a variety of intervention strategies including:

1. Crisis Intervention;

2. Brief Counseling;

3. Ongoing Individual Psychotherapy;

4. Group Psychotherapy; and

5. Psychoeducational Groups.

**B. Objective 2:** Interns will be able to select, plan, and adapt appropriate treatment modalities to the unique needs of the client.

**C. Objective 3:** Interns will have experience in the formulation of written treatment plans and in the maintenance of ongoing records of intervention.

## III. CONSULTATION

**A. Objective 1:** Interns will have the opportunity to participate in a full range of consultative activities with other departments within the institution. Examples of other departments with which interns might offer consultative services are Education, Medical, Unit Teams, Wellness, Religious Services, Personnel, etc.

**B. Objective 2:** Interns will be given the opportunity to develop and provide training both to psychology and non-psychology staff. Training activities with which interns might become involved include:

1. Institution Familiarization Training;

2. Annual Refresher Training;

3. Interdepartmental Topical Seminar; and

4. Psychology Services Case Presentation.

## IV. SCHOLARLY ACTIVITIES

**A. Objective 1:** Interns will participate in some type of professional scholarship. Specific examples of professional scholarly activities in which interns might engage include:

1. Research Activities;

2. Preparation of an article for publication;

3. Program Development and/or Evaluation;

4. Specialized Reading or Study; and

5. Dissertation Activities.

V. PROFESSIONAL DEVELOPMENT

**A. Objective 1:** Interns will participate in activities specifically oriented toward furthering their professional identity and growth. Examples of such activities might include:

1. Individual and Group Supervision;

2. Exposure to the broader professional community through participation in community-sponsored seminars, workshops, etc.;

3. Participation in departmental retreats and staff meetings;

4. the study of ethical principles;

5. work on mental health policy definitions; and

6. exploring the legal limits of practice.

**VI. DIDACTIC TRAINING**

**A. Objective 1:** Interns will receive didactic training, through regularly scheduled formal presentations and/or discussions, at a minimum, in each of the following areas:

1. Ethics;

2. Cultural Diversity;

3. Assessment;

4. Intervention;

5. Special Populations (HIV+, Substance Abusers, Geriatric, etc.);

6. Professional Issues (eg., liability/malpractice; private practice; mentoring; supervision, etc.).

**PSYCHOLOGY TRAINEE QUARTERLY EVALUATION**

**Trainee's Name:**_____ **Training Period:**_____

**Site:**_____ **Date:**_____

**DIRECTIONS:** This form should be filled out by the individual who served as the trainee's primary on-site clinical supervisor during the training period. However, feedback from all other clinical supervisors during the training period should be included in this form.

Briefly describe work performed. Rate level of proficiency by circling one number on each scale from 1 to 5:

1 = **Unsatisfactory** -- performance is unacceptable at the trainee's level.
2 = **Marginally Satisfactory** -- performance reflects need for improvement.
3 = **Satisfactory** -- performance is consistent with expectations of a trainee.
4 = **Exceeds** -- performance reflects competence at a level beyond that expected of trainee.
5 = **Outstanding** -- performance reflects a degree of competence far beyond that expected of trainee.

Circle **N/A** for **"Not Applicable"** if you have not supervised a trainee in a particular activity during this time period.

**I. ASSESSMENT SKILLS**

| **A. Interviewing/Intakes** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Assessment accuracy (ie., identifies individuals in need of psych. svc.) | 1 | 2 | 3 | 4 | 5 | - |
| 2. Disposition and Follow-up of "at-risk" cases | 1 | 2 | 3 | 4 | 5 | - |
| 3. Ability to build rapport | 1 | 2 | 3 | 4 | 5 | - |
| 4. Response to supervision (flexibility, non-defensiveness, use of feedback) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Psychological Testing** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Proper use of objective tests (e.g., MMPI, MCMI) | 1 | 2 | 3 | 4 | 5 | - |
| 2. Proper use of projective techniques (e.g., Rorschach) | 1 | 2 | 3 | 4 | 5 | - |
| 3. Proper use of intelligence tests (e.g., WAIS-R) | 1 | 2 | 3 | 4 | 5 | - |
| 4. Proper use of other tests (neuropsych,LD, achievement) | 1 | 2 | 3 | 4 | 5 | - |
| 5. Use of background information | 1 | 2 | 3 | 4 | 5 | - |
| 6. Response to supervision flexibility, non-defensive-ness, use of feedback) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **C. Report Writing** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Organization (logical sequence) | 1 | 2 | 3 | 4 | 5 | - |
| 2. Clearly answers referral questions | 1 | 2 | 3 | 4 | 5 | - |
| 3. Style (grammar, avoidance of jargon, brevity) | 1 | 2 | 3 | 4 | 5 | - |
| 4. Treatment recommendations proceed logically from test data | 1 | 2 | 3 | 4 | 5 | - |
| 5. Response to supervision (flexibility, non-defensive-ness, use of feedback) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

## II. INTERVENTION SKILLS

| **A. Individual Psychotherapy** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Assessment/Diagnosis (Understands DSM-3-R) | 1 | 2 | 3 | 4 | 5 | - |
| 2. Case Conceptualization (Personality Dynamics) | 1 | 2 | 3 | 4 | 5 | - |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. | Relationship building (Empathy, respect, awareness of cultural, ethnic issues) | 1 | 2 | 3 | 4 | 5 | - |
| 4. | Awareness of self in therapeutic relationship | 1 | 2 | 3 | 4 | 5 | - |
| 5. | Identifies client strengths as well as deficits | 1 | 2 | 3 | 4 | 5 | - |
| 6. | Formulates adequate therapy goals (goals proceed from diagnosis and reflect client concerns) | 1 | 2 | 3 | 4 | 5 | - |
| 7. | Case management (Disposition and follow-up) | 1 | 2 | 3 | 4 | 5 | - |
| 8. | Handling of termination issues | 1 | 2 | 3 | 4 | 5 | - |
| 9. | Openness to innovation and willingness to try new approaches | 1 | 2 | 3 | 4 | 5 | - |
| 10. | Response to supervision (flexibility, non-defensive-ness, etc.) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Group Psychotherapy** | | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|---|
| 1. | Understands group processes | 1 | 2 | 3 | 4 | 5 | - |
| 2. | Maintains focus (facilitates goals) | 1 | 2 | 3 | 4 | 5 | - |
| 3. | Relationship building (Empathy, respect, awareness of ethnic/cultural issues) | 1 | 2 | 3 | 4 | 5 | - |
| 4. | Works with co-leader (where appropriate) | 1 | 2 | 3 | 4 | 5 | - |
| 5. | Case management (Disposition and follow-up) | 1 | 2 | 3 | 4 | 5 | - |
| 6. | Handling of termination issues | 1 | 2 | 3 | 4 | 5 | - |
| 7. | Response to supervision flexibility, non-defensive-ness, use of feedback) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **C. Crisis Intervention/ Brief Counseling** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Knows limits of own competence, seeks supervision at appropriate times | 1 | 2 | 3 | 4 | 5 | - |
| 2. Awareness of diagnostic indicators of suicide, psychosis | 1 | 2 | 3 | 4 | 5 | - |
| 3. Awareness of crisis intervention procedures | 1 | 2 | 3 | 4 | 5 | - |
| 4. Clinical skills in crisis situations | 1 | 2 | 3 | 4 | 5 | - |
| 5. Response to supervision flexibility, non-defensive-ness, use of feedback) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

## III. CONSULTATION SKILLS

| **A. Interdepartmental** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Ability to consult with other disciplines | 1 | 2 | 3 | 4 | 5 | - |
| 2. Response to supervision (flexibility, non-defensive-ness, use of feedback) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Training Activities** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Didactic programs for psychology staff | 1 | 2 | 3 | 4 | 5 | - |
| 2. In-service training to non-psychology staff | 1 | 2 | 3 | 4 | 5 | - |
| 3. Supervision of practicum students | 1 | 2 | 3 | 4 | 5 | - |
| 4. Response to supervision (flexibility, non-defensive-ness, use of feedback) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

## IV. SCHOLARLY ACTIVITIES

| **A. Research Activities** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Works toward completion of research project(s) | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Program Development/ Program Evaluation** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Enhances existing programs with innovative ideas | 1 | 2 | 3 | 4 | 5 | - |
| 2. Develops new program which meets inmate or staff need | 1 | 2 | 3 | 4 | 5 | - |
| 3. Conducts program evaluation on new or existing program | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **C. Other Activities** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Prepares Scholarly publication | 1 | 2 | 3 | 4 | 5 | - |
| 2. engages in specialized readings or study | 1 | 2 | 3 | 4 | 5 | - |

Comments:

## V. PROFESSIONAL DEVELOPMENT

| **A. Personal Adjustment To Duties** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Adheres to ethical standards | 1 | 2 | 3 | 4 | 5 | - |
| 2. Conscientiousness, responsibility | 1 | 2 | 3 | 4 | 5 | - |
| 3. Ability to work with other psychology staff | 1 | 2 | 3 | 4 | 5 | - |
| 4. Ability to work with non-psychology staff | 1 | 2 | 3 | 4 | 5 | - |
| 5. Professional grooming and appearance | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Involvement with Community Professionals** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Seeks out and effectively utilizes available community resources | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **C. Other Professional Activities** (Specify) | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. | 1 | 2 | 3 | 4 | 5 | - |
| 2. | 1 | 2 | 3 | 4 | 5 | - |
| 3. | 1 | 2 | 3 | 4 | 5 | - |

Comments:

**D. Supervision**

1. Type provided and number of hours per week (including, specifically, the number of hours of one-to-one supervision provided per week by individuals licensed as clinical psychologists in state where supervision is provided):

2. General Comments on Trainee's Response to Supervision:

## VI. DIDACTIC PROGRAM

| **A. Program Involvement** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Regularly attends didactic programs | 1 | 2 | 3 | 4 | 5 | - |
| 2. actively participates in didactic programs | 1 | 2 | 3 | 4 | 5 | - |

Comments:

**OVERALL PERFORMANCE RATING**

☐ **One or More Performance Weaknesses Noted**

☐ **Satisfactory Performance**

Recommended Remedial Actions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Typed Name:

_____
Clinical Supervisor

Signature:

_____
Clinical Supervisor

Received and Discussed with:
Typed Name:

_____
Psychology Trainee

Signature:

_____
Psychology Trainee

# QUARTERLY PSYCHOLOGY TRAINING PROGRAM EVALUATION

**Trainee's Name:**_____ **Training Period**:_____

**Site:**_____ **Date:**_____

**DIRECTIONS:** This quarterly evaluation will help the staff to insure the quality of the remainder of your training and to make long-range plans that will benefit future trainees. Please fill out one form for each of the sites at which you trained this quarter.

Rate each of the following items by circling one number on each 5-point scale. Please use the following general guidelines in determining your rating:

1 = **Unsatisfactory** -- quality/amount was of an unacceptable level for this type of training program; contributed nothing to my professional growth.
2 = **Marginally Satisfactory** -- need for improvement in quality/amount in this area; contributed some-what to my professional growth.
3 = **Satisfactory** -- quality/amount was consistent with my expectations; contributed adequately to my professional growth.
4 = **Exceeds** -- quality/amount was greater that the level I anticipated; made significant contribution to my professional growth.
5 = **Outstanding** -- quality/amount was of an unusually high degree; made highly significant contribution to my professional growth.

Circle **N/A** for **"Not Applicable"** where appropriate.

## I. ASSESSMENT EXPERIENCE/SUPERVISION

| **A. Interviewing/Intakes** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Experience facilitates: | | | | | | |
| a. understanding individual differences | 1 | 2 | 3 | 4 | 5 | - |
| b. understanding diagnostic issues & client population | 1 | 2 | 3 | 4 | 5 | - |
| c. interview style and efficiency | 1 | 2 | 3 | 4 | 5 | - |

| 2. Supervisor facilitates: | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| a. understanding of procedures involved | 1 | 2 | 3 | 4 | 5 | - |
| b. understanding of relevant mental health issues | 1 | 2 | 3 | 4 | 5 | - |
| c. focus on clinical style/ process | 1 | 2 | 3 | 4 | 5 | - |
| d. understanding of diagnostic issues | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Psychological Testing** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Experience facilitates: | | | | | | |
| a. objective test skills (e.g., MMPI, MCMI) | 1 | 2 | 3 | 4 | 5 | - |
| b. projective test skills (e.g., Rorschach, TAT) | 1 | 2 | 3 | 4 | 5 | - |
| c. intelligence testing skills (e.g., WAIS-R) | 1 | 2 | 3 | 4 | 5 | - |
| d. other test skills (e.g., neuropsych, achievement) | 1 | 2 | 3 | 4 | 5 | - |
| e. good use of background/ observation data | 1 | 2 | 3 | 4 | 5 | - |
| f. understanding diagnostic issues and client population | 1 | 2 | 3 | 4 | 5 | - |
| 2. Supervisor facilitates: | | | | | | |
| a. objective test skills (e.g., MMPI, MCMI) | 1 | 2 | 3 | 4 | 5 | - |
| b. projective test skills (e.g., Rorschach, TAT) | 1 | 2 | 3 | 4 | 5 | - |
| c. intelligence test skills (e.g., WAIS-R) | 1 | 2 | 3 | 4 | 5 | - |
| d. other test skills (e.g., neuropsych, achievement) | 1 | 2 | 3 | 4 | 5 | - |
| e. good use of background/ observation data | 1 | 2 | 3 | 4 | 5 | - |
| f. understanding diagnostic issues and client population | 1 | 2 | 3 | 4 | 5 | - |

Comments:

**C. Report Writing**

| 1. Experience facilitates: | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| a. efficient use of time | 1 | 2 | 3 | 4 | 5 | - |
| b. understanding of diagnostic issues and client population | 1 | 2 | 3 | 4 | 5 | - |
| c. treatment recommendations based on test data and other relevant information | 1 | 2 | 3 | 4 | 5 | - |
| 2. Supervisor facilitates: | | | | | | |
| a. integrating data | 1 | 2 | 3 | 4 | 5 | - |
| b. organization of report | 1 | 2 | 3 | 4 | 5 | - |
| c. addressing referral question | 1 | 2 | 3 | 4 | 5 | - |
| d. style (e.g., grammar, avoidance of jargon,etc.) | 1 | 2 | 3 | 4 | 5 | - |
| e. treatment recommendations based on test data and other relevant information | 1 | 2 | 3 | 4 | 5 | - |
| f. understanding diagnostic issues and client population | 1 | 2 | 3 | 4 | 5 | - |

Comments:

## II. INTERVENTION EXPERIENCE/SUPERVISION

| **A. Individual Psychotherapy** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Experience facilitates: | | | | | | |
| a. case conceptualization | 1 | 2 | 3 | 4 | 5 | - |
| b. goal setting/assessment | 1 | 2 | 3 | 4 | 5 | - |
| c. relationship building | 1 | 2 | 3 | 4 | 5 | - |
| d. personal style | 1 | 2 | 3 | 4 | 5 | - |
| e. process issues | 1 | 2 | 3 | 4 | 5 | - |
| f. use of specific techniques | 1 | 2 | 3 | 4 | 5 | - |
| g. case preparation/ management skills | 1 | 2 | 3 | 4 | 5 | - |
| h. diagnostic skills | 1 | 2 | 3 | 4 | 5 | - |
| i. handling termination | 1 | 2 | 3 | 4 | 5 | - |

| 2. Supervisor facilitates: | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| a. case conceptualization | 1 | 2 | 3 | 4 | 5 | - |
| b. goal setting | 1 | 2 | 3 | 4 | 5 | - |
| c. relationship building | 1 | 2 | 3 | 4 | 5 | - |
| d. understanding of process issues | 1 | 2 | 3 | 4 | 5 | - |
| e. enhancement of personal style | 1 | 2 | 3 | 4 | 5 | - |
| f. diagnostic acumen | 1 | 2 | 3 | 4 | 5 | - |
| g. ability to use specific techniques | 1 | 2 | 3 | 4 | 5 | - |
| h. case preparation/ management skills | 1 | 2 | 3 | 4 | 5 | - |
| i. handling of termination issues | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Group Psychotherapy** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Experience facilitates: | | | | | | |
| a. understanding of group processes | 1 | 2 | 3 | 4 | 5 | - |
| b. goal setting/assessment | 1 | 2 | 3 | 4 | 5 | - |
| c. planning for group (inc. outlines, lesson plans) | 1 | 2 | 3 | 4 | 5 | - |
| d. ability to work with coleader (if applicable) | 1 | 2 | 3 | 4 | 5 | - |
| e. maintaining focus of the group | 1 | 2 | 3 | 4 | 5 | - |
| f. Case preparation/ management skills | 1 | 2 | 3 | 4 | 5 | - |
| g. use of specific techniques | 1 | 2 | 3 | 4 | 5 | - |
| h. comfort in group setting | 1 | 2 | 3 | 4 | 5 | - |
| i. handling of termination issues | 1 | 2 | 3 | 4 | 5 | - |
| 2. Supervisor facilitates: | | | | | | |
| a. understanding of group process | 1 | 2 | 3 | 4 | 5 | - |
| b. goal setting (making group relevant) | 1 | 2 | 3 | 4 | 5 | - |
| c. planning for group (inc. outline, lesson plan) | 1 | 2 | 3 | 4 | 5 | - |
| d. ability to work with coleader (if applicable) | 1 | 2 | 3 | 4 | 5 | - |

| | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| e. maintaining focus of group | 1 | 2 | 3 | 4 | 5 | - |
| f. case preparation/ management skills | 1 | 2 | 3 | 4 | 5 | - |
| g. ability to use specific techniques | 1 | 2 | 3 | 4 | 5 | - |
| h. ability to innovate | 1 | 2 | 3 | 4 | 5 | - |
| i. understanding of termination issues | 1 | 2 | 3 | 4 | 5 | - |

Comments:

**C. Crisis Intervention/ Brief Counseling**

| | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Experience facilitates: | | | | | | |
| a. case conceptualization | 1 | 2 | 3 | 4 | 5 | - |
| b. goal setting/assessment | 1 | 2 | 3 | 4 | 5 | - |
| c. relationship building | 1 | 2 | 3 | 4 | 5 | - |
| d. personal style | 1 | 2 | 3 | 4 | 5 | - |
| e. process issues | 1 | 2 | 3 | 4 | 5 | - |
| f. use of specific techniques | 1 | 2 | 3 | 4 | 5 | - |
| g. case preparation/ management skills | 1 | 2 | 3 | 4 | 5 | - |
| h. diagnostic skills | 1 | 2 | 3 | 4 | 5 | - |
| i. handling termination | 1 | 2 | 3 | 4 | 5 | - |
| 2. Supervisor facilitates: | | | | | | |
| a. case conceptualization | 1 | 2 | 3 | 4 | 5 | - |
| b. goal setting/assessment | 1 | 2 | 3 | 4 | 5 | - |
| c. relationship building | 1 | 2 | 3 | 4 | 5 | - |
| d. personal style | 1 | 2 | 3 | 4 | 5 | - |
| e. process issues | 1 | 2 | 3 | 4 | 5 | - |
| f. use of specific techniques | 1 | 2 | 3 | 4 | 5 | - |
| g. case preparation/ management skills | 1 | 2 | 3 | 4 | 5 | - |
| h. diagnostic skills | 1 | 2 | 3 | 4 | 5 | - |
| i. handling termination | 1 | 2 | 3 | 4 | 5 | - |

Comments:

## III. CONSULTATION AND TRAINING EXPERIENCE/SUPERVISION

| **A. Interdepartmental Consultation** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Experience facilitates: | | | | | | |
| a. application of psychological information to other disciplines (eg., hospital, unit teams, correctional staff, etc.) | 1 | 2 | 3 | 4 | 5 | - |
| 2. Supervision facilitates: | | | | | | |
| a. opportunity to share psychological information with other disciplines | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Training Activities** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Training received on site (adequacy and quality) | 1 | 2 | 3 | 4 | 5 | - |
| 2. Training received off site (adequacy and quality) | 1 | 2 | 3 | 4 | 5 | - |
| 3. Orientation to Training Program (first Quarter Only) | 1 | 2 | 3 | 4 | 5 | - |
| 4. Opportunity to offer training to Psychology Staff (eg., didactic presentations, case presentations, etc.) | 1 | 2 | 3 | 4 | 5 | - |
| 5. Opportunity to offer training to Non-Psychology Staff | 1 | 2 | 3 | 4 | 5 | - |
| 6. Supervision of Practicum students | 1 | 2 | 3 | 4 | 5 | - |
| 7. Supervision on training activities | 1 | 2 | 3 | 4 | 5 | - |

Comments:

## IV. SCHOLARLY ACTIVITIES

| **A. Research/Program Development** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. Adequacy of time allowed for research activities | 1 | 2 | 3 | 4 | 5 | - |
| 2. Access to computer/ statistical resources | 1 | 2 | 3 | 4 | 5 | - |
| 3. Supervision on research information and activities | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **B. Other Activities** (Please Specify) | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| 1. | 1 | 2 | 3 | 4 | 5 | - |
| 2. | 1 | 2 | 3 | 4 | 5 | - |
| 3. | 1 | 2 | 3 | 4 | 5 | - |

Comments:

| **V. OVERALL PROGRAM RATINGS** | Unsatis. | | | | Outst. | N/A |
|---|---|---|---|---|---|---|
| A. Availability of staff | 1 | 2 | 3 | 4 | 5 | - |
| B. Acceptance by staff | 1 | 2 | 3 | 4 | 5 | - |
| C. Expertise of staff | 1 | 2 | 3 | 4 | 5 | - |
| D. Quality of Traineeship Experience | 1 | 2 | 3 | 4 | 5 | - |
| E. Quality of Supervision | 1 | 2 | 3 | 4 | 5 | - |

Comments:

**********

On a separate sheet of paper please make any additional comments which you feel could be used to improve this Psychology Training Program.

**********

**POSITION DESCRIPTION**
**Psychology Postdoctoral Resident**
**GS-180-11**

This position is located at _____.
The Psychology Post-Doctoral Trainee works under the primary supervision of a licensed clinical or counseling psychologist who is employed by the Federal Bureau of Prisons in a psychology specialty area (such as drug abuse treatment, sex offender treatment, forensic assessment, neuropsychological assessment, industrial/organizational psychology, etc). The Psychology Post-Doctoral Trainee must possess a doctoral degree in clinical or counseling psychology from a regionally accredited graduate psychology training program, preferably a program which has also been approved by the American Psychological Association. As a trainee, the incumbent will receive supervised clinical experience in one correctional psychology specialty area. Initial incumbent selection is made by the institution's Director of Psychology Training and/or Chief Psychologist. Final responsibility for selection rests with the Bureau of Prison's Central Office Psychology Services Clinical Programs Coordinator.

At this level of training the incumbent's ability to provide services as well as to grow professionally are prime factors for evaluating the trainee's effectiveness as a psychologist. This assignment is planned as a training position which provides intensive and continuous practical experience in the utilization of advanced techniques and procedures as they apply to the practice of a specific specialty area within the broader field of correctional psychology.

As a member of an interdisciplinary team with at least three hours per week of supervision by a licensed, doctoral level specialty psychologist, the incumbent provides professional psychological services within his/her specialty area. Specific services might include, but are not limited to: diagnostics or assessments, therapy or treatment, research or program evaluation, and in-service training. The incumbent aids staff in formulating programs for inmates and/or staff. The incumbent conducts and/or aids in staff training and consults with staff at all levels regarding treatment, training, and research within his/her specialty area. The incumbent keeps abreast of new trends and techniques, develops and improves professional skills, and maintains contact with the academic and professional community. The incumbent assists in administrative functions of the department as they relate to his/her specialty area.

**1. Knowledge and/or Ability Required by the Position**

A. Course work in theories of personality, abnormal behavior, and psychopathology.

B. Course work which covers the appropriate use, construction, theoretical rationale, and interpretation of assessment instruments in such areas as personality, intellectual, neuropsychological, and vocational functioning.

C. Course work and/or practicum experience in clinical interview techniques, diagnostic and classification systems, and psychological report writing.

D. Course work and/or experience in basic program development/evaluation and/or research methodologies and statistical procedures.

E. Knowledge of ethical and professional aspects of a psychology services delivery system.

**2. Supervisory Controls**

A. The incumbent will address professional issues and arrive at clinical decisions through careful and regular supervision/consultation with a licensed, doctoral-level specialty psychologist. Primary responsibility for all decisions made by the trainee will ultimately rest with his/her immediate clinical supervisor.

B. For administrative and operational issues, the incumbent works under the general supervision of the Director of Psychology Training and/or the Chief, Psychology Services.

C. Psychology Post-Doctoral Trainees will receive quarterly performance evaluations which will be completed by either the Chief, Psychology Services, the Director of Psychology Training, or the trainee's primary clinical supervisor.

**3. Guidelines**

A. The incumbent conforms to all ethical standards set forth by the American Psychological Association, by Federal Regulations, and by Bureau of Prison's policy.

**4. Complexity**

A. Within his/her specialty area, the incumbent provides professional psychological services to clients who represent a broad range of emotional, personality, mental, neurological, vocational, educational, and social problems. Since many traditional therapeutic techniques have limited effectiveness with prison inmates, the incumbent will be expected to exercise ingenuity in adapting and extending existing methods or procedures in arriving at appropriate, innovative therapy techniques.

B. Within his/her specialty area, the incumbent provides consultation and training to institution staff who vary widely in background, education, sophistication, and receptiveness to psychological principles. Therefore, ingenuity and creativity are required to adapt and extend existing methods of teaching, training, and consultation.

**5. Scope and Effect**

A. Clinical recommendations and/or decisions have impact on a large number of inmate clients.

B. Discovering effective techniques for working with inmate clients may represent significant extensions of existing theories and concepts for psychology and corrections.

C. Psychological evaluations and/or recommendations have wide impact and influence which include the local institution, U.S. Parole Commission, and U.S. Courts.

D. Research, consultation, committee membership, and training activities have wide impact potentially affecting policies, procedures, programs, and operations of the institution, the Bureau of Prisons, and correctional facilities in general.

**6. Personal Contacts**

A. Personal contacts are a continuing and vital part of the work. They include inmate clients, other psychologists, physicians and other medical staff, institution staff at all levels, U.S. Parole Commission Examiners, Bureau of Prisons Regional and Central Office staff, and members of the professional and academic community.

**7. Purpose of Contacts**

A. Inmate patient contacts are for purposes of observation, interview, treatment, and research. Contacts with institution staff are for purposes of obtaining assessment information, discussing particular cases, sharing views on professional matters, devising and implementing appropriate treatment programs, and making recommendations and decisions for a variety of program and administrative dispositions. Thus, the incumbent will contribute directly to the establishment of a positive treatment milieu such as will enhance the overall institutional rehabilitation program and the well being of clients.

**8. Physical Demands**

A. The work is generally sedentary. However, under emergency conditions the incumbent must be prepared to defend himself/herself and/or assist others in subduing recalcitrant inmates.

**9. Work Environment**

A. The duties of this position require direct contact with individuals in confinement who are suspected or convicted of offenses against the criminal laws of the United States.

B. Daily stress and exposure to potentially dangerous situations such as physical attack are an inherent part of this position.

# CHAPTER 8

# SPECIAL CLINICAL/CONSULTATION PROGRAMS

The Bureau encourages psychologists to apply their expertise in the behavioral sciences to issues and problems facing the field of corrections. BOP psychologists, depending on their academic preparation and clinical training, may offer an array of clinical/consultation services to correctional workers and administrators.

## 8.1 HOSTAGE NEGOTIATION PROGRAM

Psychology Services has taken an active role in the development of the Bureau's Hostage Negotiation Program.

### A. TRAINING ACTIVITIES

A team of specially trained BOP psychologists conducts a 34 hour hostage negotiation training program for BOP staff on a regular basis at the Bureau's MSTC, Aurora, Colorado.

All institutions with SORT capability are expected to form hostage negotiation teams. These negotiation teams receive national training on a biannual basis, are expected to practice monthly at the local level, and are required to practice with other components of their institution's emergency preparedness team (i.e., SORT and Command Center personnel) semi-annually.

(1) It is only through regular training that a negotiation team can develop the skill needed to successfully resolve an actual hostage situation.

(2) One way that institution negotiation teams can apply their negotiation skills on a regular basis is to become involved in the institution's confrontation avoidance program.

### B. NEGOTIATION TEAM

The Bureau uses a team approach to hostage negotiation. Negotiation team members include a team leader, a primary negotiator, a secondary or back-up negotiator, a mental health expert, and a recorder.

**C. PSYCHOLOGY ROLES IN HOSTAGE SITUATION MANAGEMENT**

In institutions where formation of a negotiation team is mandated, one psychologist should be designated from the Psychology Department to serve as the team's mental health consultant. In this capacity, the psychologist should not only practice with the negotiation team on a monthly basis, but should also assist the team leader in developing training scenarios for the team and in instructing team members on psychological phenomena related to hostage situations (e.g., Stockholm Syndrome, stress management techniques, effective intervention strategies, etc.). In institutions with several psychologists, the Chief Psychologist may also serve as the team leader at the discretion of the Warden.

In addition, as a member of the institution's hostage negotiation team, psychologists may be called upon to train other institution staff in hostage survival skills during Annual Refresher Training.

---

BOP Program Statement on "Hostage Situation Management" is referenced for more detailed information regarding the Bureau's Hostage Negotiation Program.

## 8.2 FAMILY AND EMPLOYEE ASSISTANCE TEAM (FEAT) (CRITICAL INCIDENT RESPONSE TEAMS)

Among the newer components of the Bureau's Employee Assistance Program is the development of the Family and Employee Assistance Team (FEAT). This team, consisting of a psychologist, a chaplain, and support staff, is tasked with providing assistance to employees who have been involved in traumatic events such as assaults, hostage situations, staff death/suicide, natural disasters, or other emergency situations which may have an adverse psychological impact.

Through this program, crisis counseling, psychological and spiritual care, and support services are offered to Bureau employees who have been involved in a traumatic event and, when appropriate, to family members who have been negatively impacted by this event. Staff members who have witnessed traumatic events or who have assisted in the management of traumatic events may also avail themselves to post incident, employee assistance services.

Research has shown that being the victim of a traumatic event can lead to the development of disturbing psychological and physiological symptoms. When victims receive early support and therapeutic intervention, these symptoms can often be moderated. When no services are received, victims may develop symptoms of post-traumatic stress disorder.

Specialized training in critical incident counseling is periodically offered to interested psychologists, chaplains, and support staff through the MSTC.

## 8.3 RESEARCH AND PROGRAM EVALUATION

The academic preparation which many psychologists acquire during their graduate training in such areas as basic statistics and research design enables them to be useful in designing and participating in their institution's research and/or program evaluation efforts.

### A. RESEARCH APPROVAL PROCESS

Research proposals generated at the institutional level should be submitted to, and approved by, the institution's Research Committee and Warden.

(1) Research proposals submitted for approval by Bureau psychologists should be, as much as possible, of an applied nature.

(2) Typically, the Chief Psychologist serves as chairperson of the institution's research committee, and as such, may have primary responsibility to insure completion of the project.

Following approval at the institution level, research proposals should be submitted to the Regional Director for review and approval. Ordinarily, the Regional Psychology Administrator is delegated the responsibility to review proposals for Regional Office approval. Following Regional Office approval, the Chief, Office of Research, is required to review and approve all research for the Director of the Bureau.

### B. PUBLICATION OF RESEARCH FINDINGS

When submitting research findings for publication, the author(s) must, in the case of formal research projects, acknowledge that the research was done under the auspices of the Federal Bureau of Prisons. However, regardless of article content, material submitted for publication must clearly state that the views expressed are those of the author(s) only and do not represent the official policy or opinions of the Federal Bureau of Prisons. Prior to submitting material for publication, it is recommended that a copy be forwarded to the Warden.

BOP Program Statement on "Research" is referenced for more detailed information about the format for research proposals and regarding the research approval process.

## 8.4 OTHER CLINICAL/CONSULTATION PROGRAMS

### A. STAFF CONSULTATION

Psychologists routinely consult with unit, education, medical, and correctional staff and with various inmate detail supervisors regarding special needs offenders. These consultations typically serve to educate staff about the special needs of specific inmates and can help staff in their routine management of these cases.

### B. PROGRAM DEVELOPMENT/PSYCHOLOGY WORKGROUPS

Psychology staff may apply their behavioral science expertise to the development of institutional programs aimed at creating a safer, more humane living environment for inmates or a more productive, comfortable work environment for staff. Consultations of this type take several forms.

(1) Psychologists, through their participation on Psychology Services' Workgroups, often use their expertise in the development and implementation of therapeutic programs such as the Drug Abuse Treatment Program or the Sex Offender Treatment Program which address the unique treatment needs of the inmate population.

(2) Psychology consultations may also take the form of developing programs which address the unique needs of staff. The development and implementation of specialized training programs for correctional counselors or new supervisors, coordination of staff retreats for strategic planning and/or problem resolution purposes, and participation on institution committees are all examples of this type of consultation.

### C. CONSULTATION WITH MANAGEMENT AND ADMINISTRATIVE STAFF

Periodically, Psychology staff are asked by institution administrators to develop questionnaires or surveys which solicit staff opinion on institutional issues and/or concerns. Results of such surveys often help administrators to identify problem areas and to develop appropriate corrective actions.

Consultations with administrative staff may also take the form of developing or implementing institutional intervention strategies which apply behavioral science principles to correctional management issues. The use of unit assignment systems such as the Quay or Megargee Inmate Classification System are examples of applying psychological principles to address institutional concerns.

**D. COMMUNITY PROGRAMS/SEMINARS**

On occasion, psychologists are asked by local universities, colleges, law enforcement agencies, mental health facilities, or civic groups to share their expertise regarding correctional psychology issues. BOP psychologists are encouraged to share their expertise with outside agencies so long as this activity does not conflict with job demands or Bureau policy. Questions about Bureau policy in this area can be referred to the Bureau's Office on Ethics, which is located in the Central Office.

# CHAPTER 9

# PSYCHOLOGY EVALUATION PROGRAMS

Bureau of Prison's psychologists provide psychological assessment/evaluation services to a number of clients including the Federal Courts, the U.S. Parole Commission, the Justice Department's Office of Enforcement Operations, and other Bureau components.

## 9.1 FORENSIC EVALUATION PROGRAM

The Bureau of Prisons has been assigned the task of providing the Federal Courts with psychological and/or psychiatric evaluations on pretrial detainees when issues of competence and/or criminal responsibility are raised. These provisions are defined in Title 18, U.S. Code, Sections 4241(b) and 4242. Procedures and issues related to the completion of these comprehensive assessments are outlined below.

### A. LOCATIONS OF FORENSIC STUDY SITES

Forensic assessments will ordinarily be completed at one of the Bureau's psychiatric referral centers or forensic study sites. These sites are as follows:

| Psychiatric Referral Centers | Forensic Study Sites |
|---|---|
| FCI, Butner, North Carolina | USP, Atlanta, Georgia |
| FMC, Rochester, Minnesota | MCC, Chicago, Illinois |
| MCFP, Springfield, Missouri | FCI, Fairton, New Jersey |
| FMC, Lexington, Kentucky (female offenders only) | FCI, Fort Worth, Texas |
| | MDC, Los Angeles, Calif. |
| | MCC, Miami, Florida |
| | FCI, Milan, Michigan |
| | MCC, New York, New York |
| | FCI, Petersburg, Virginia |
| | MCC, San Diego, California |

On those rare occasions when a Title 18, U.S. Code, Section 4241(b) or 4242 case is sent to a regular correctional institution that does not have a forensic study site, every effort should be made to have the case redesignated as soon as possible. If redesignation is not possible, the forensic assessment may be completed at that facility provided that it is completed by a legally qualified evaluator. In these circumstances, it is recommended that the evaluator consult with a clinician from one of the above sites who routinely completes these types of assessments.

All other assessment and/or treatment provisions referred to in Chapter 313 of Title 18, U.S. Code, Sections 4241-4246, require hospitalization and must, therefore, be completed in one of the Bureau's four psychiatric referral centers. Since statute requires that these studies be completed in a hospital setting, if one is inadvertently assigned to a regular correctional facility or forensic study site, the Medical Designator should be contacted immediately and that designation appropriately changed.

As in the past, studies designated under Title 18, U.S. Code, Sections 4205(c) and 3552 may be completed at any institution having appropriately qualified mental health staff.

For specific requirements in regard to physically housing study cases, the BOP Program Statement on "Pre-trial Inmates" is referenced.

## B. FORENSIC EVALUATORS

(1) Qualifications

Federal law stipulates that only licensed or certified psychiatrists and psychologists can perform forensic evaluations ordered pursuant to Chapter 313, Title 18, U.S. Code, Sections 4241-4246. The Bureau of Prisons encourages participation by psychology interns, post-doctoral fellows, and persons pursuing licensure in the forensic process. However, it is critical that an appropriately licensed clinician take full responsibility for the final product and opinion. This person must be fully involved in all aspects of the evaluation and be prepared to testify if called. The possibility always exists that persons other than the licensed clinician could be subpoenaed. However, at no time should they be portrayed as the primary evaluator, nor should attorneys ever be encouraged to subpoena them in lieu of the primary evaluator.

(2) Staffing

To ensure that timely completion, consistent quality, and predictable work levels are maintained at all institutions where forensic assessments are conducted, it is recommended that at least two clinicians trained to perform forensic studies, one full-time and the other for back-up and overflow, be assigned to the program.

For psychologists assigned to the Forensic Assessment Program, the requirements for licensure, experience, and independent functioning qualifies these positions to carry a grade of GS-13. As much as possible, this position should be used for the purpose of providing forensic evaluations, but may be used in other Psychology Department activities if time and workloads permit.

(3) Training

Before being assigned as a forensic evaluator, each clinician must be able to demonstrate basic forensic training and experience or work under the direct supervision of someone who has it. The Central Office Psychology Administrator will be responsible for scheduling training sessions on an as needed basis to enhance and update forensic skills for evaluators.

In an effort to further enhance the training and supervision offered to forensic clinicians, a system of mentorship has also been established for clinicians located at sites without an experienced forensic evaluator. Under this mentorship system, psychologists new to the forensic assessment process will be linked with a more experienced forensic psychologist at another study site. Clinicians are encouraged to seek regular professional consultation with their mentor and forward sample reports for review until such time as both the clinician and mentor agree that this review process is no longer necessary.

## C. FORENSIC EVALUATION TIME FRAMES

Time frames for completion of forensic evaluations are specified in statute; strict adherence to established time frames is required. Time frames specified by statute are for custody of the inmate. Therefore, unless otherwise specified in the court order or unless the inmate is not in custody prior to arrival at an institution (i.e., a self-surrender), the time of the evaluation begins on the date the court order is signed. The final day of the study is the day on which the Bureau of Prisons must be ready to relinquish custody of the inmate. To accomplish this, it is essential that the evaluator, through the ISM Department, be proactive in notifying the U.S. Marshals Service in a timely fashion so that they may pick the inmate up on that day. All evaluative contact with the inmate, including interviews, testing, etc., must be completed at that time so the inmate may be transported. However, that date does not reflect the time in which a report is due in court. Statute does not specify a limitation on this. Ordinarily, however, the report should be forwarded not more than two weeks after the final date of the study.

Maximum time permitted by statute for specific studies is as follows:

| | |
|---|---|
| 4241(b)-Competency Study: | 30-days, with a possible 15-day extension. |
| 4242-Responsibility: | 45-days, with a possible 30-day extension. |
| 4241(b) and 4242 combined: | 45-days, with a possible 30-day extension. |
| 4241(d)-Treatment to Restore Competence: | 120 days, with an extension only if the substantial probability exists that, with additional treatment, the inmate will become competent in the foreseeable future. |
| 4243(b)-Dangerousness due to Mental Disease or Defect: | 45-days, with a possible 30- day extension. |
| 4244(b)-Need for Treatment: | 30-days, with a possible 15-day extension. |

## D. ISSUES RELATED TO THE FORENSIC EVALUATION PROCESS

(1) Providing Treatment for Forensic Cases

Policy and professional ethics dictate that psychologists completing forensic evaluations make every effort to avoid role conflicts. Whenever possible, the forensic evaluator should not be the person providing therapy or otherwise overseeing the treatment of the person being evaluated.

Study cases referred under Title 18, U.S. Code, Sections 4241(b) and 4242, are referred primarily for evaluation and not treatment. However, necessary crisis intervention must always be provided by an appropriate professional. Should a physician (preferably a psychiatrist) determine that psychotropic medication is needed for the treatment of the mental illness of a person so referred, the forensic evaluator must first notify the committing court and allow them an opportunity to raise any objections. The person making the contact should not request the court's permission, but only ask if they have any objections to the proposed treatment.

When an inmate arrives at an institution on medication and the physician seeks to continue it, medication can be continued without interruption and a call made to the court on the first working day after the inmate's arrival. As with any other inmate, a forensic case must be competent and willing to provide written informed consent or there must be a bona fide emergency prior to administering medication (reference Health Services Manual, Section 6605). Regulations governing the treatment of hospitalized forensic cases (both voluntary and involuntary) are complex. For a more detailed discussion of this topic, the Health Services Manual is referenced.

(2) Confidentiality

Prior to the initial interview, the forensic evaluator must inform the inmate about the limits to confidentiality which exist in a forensic evaluation. The nature of the study and questions raised by the court must also be explained. The inmate should be told that all things learned from him or her or about him or her may be included in a report to the court. The inmate should also be informed that staff may be subpoenaed to testify at a later hearing regarding the his or her mental status.

Conducting telephone interviews with family members, arresting officers, or others with valuable information is encouraged. However, prior to such an interview, these persons must also be informed of the nature of the study and lack of confidentiality described above.

The issue of the confidentiality warning must be documented in the final report. Although it is permissible to have this information contained in a form that is read and explained to the individual being evaluated, any form used should not state or imply that the person is giving informed consent to the evaluation or waiving rights to decline answering questions. If a form is being used and the individual does not seem to understand it, he/she should not be offered the opportunity to sign it. This, and the reason why, should be documented on the form. It is quite probable that a good number of cases will not be competent to do so and yet the evaluation must still be completed. Since the court has ordered the evaluation, the inmates have already been given their due process rights.

(3) Professional Role Responsibilities

Any BOP mental health professional is performing a forensic evaluation directly for the federal court. Such a person does not work for the United States Attorney, nor for the defense. To maintain this position, it is essential that the forensic evaluator not favor either attorney in this process. Evaluators are encouraged to telephone both attorneys at the beginning of the study, request specific documents and records needed, and ask if either has anything they wish to provide and deem relevant. Neither attorney should be given a final opinion on a forensic issue prior to the court being notified. The evaluator must support his or her professional opinion and not create a case for either side. If, following the completion of a forensic evaluation, the evaluator is subpoenaed, he or she should insist on a pretrial conference with the subpoenaing attorney and be available for consultation with the other side (if requested).

(4) Receipt of Incident Reports

Any inmates, pretrial or otherwise, may receive an incident report while in the Bureau's custody. In the case of an inmate undergoing any forensic evaluation, that incident report should be forwarded to the primary evaluator for an opinion of competence and responsibility prior to initiating any disciplinary procedures. Policy does not specify time frames in which such an evaluation must be completed, and the evaluator may take whatever time necessary. When performing evaluations requested by, or conducted for, the institution, clinicians should conduct those evaluations in a way that does not compromise their role as forensic evaluators or the final opinions which they will eventually submit to the court.

## E. FORENSIC EVALUATION PROCEDURES

(1) Information Gathering

Forensic evaluations should not be limited to clinical interviews and psychological testing. These evaluations must also include review of collateral material such as a description of the offense behavior, investigative reports, past criminal history, and past medical or mental health treatment records. Each institution should establish a formal system for obtaining this information rapidly. Frequently, this can be done through official sources or phone interviews with attorneys or family members. It is

encouraged, but not necessary, to obtain consent from the inmate before seeking information from other than official sources. All documents collected during the forensic evaluation should become part of the inmate's Psychology File.

(2) Psychological Test Data

To complete a forensic evaluation, the specific psychological tests used should be carefully considered. Any test selected should have direct relevance to the forensic task at hand. Care should be taken to give tests with well established validity and reliability, since these tests will better withstand close scrutiny during trial.

It is the APA's position that psychological raw test data is a unique entity and should be released only to a professional properly qualified to interpret the data. Consequently, raw test data cannot be released without a court order. If the evaluator becomes aware that a court order is contemplated, he or she should request, in writing, that the court only release the data to an appropriately qualified psychologist.

(3) Report Format

Each report completed pursuant to Title 18, U.S. Code, Sections 4241 through 4246, must, by law, contain the following information:

(a) Personal history and present symptoms.

(b) Description of all psychological, psychiatric, and medical tests that were performed, as well as the results.

(c) The evaluator's findings.

(d) A current diagnosis (in proper DSM-III-R format).

(e) A prognosis.

(f) The evaluator's opinion on the court's question(s). (Final opinions should normally be stated in the exact wording of the statute. On very rare occasions, it may not be possible to reach an opinion with a reasonable degree of clinical certainty. In such cases this should be stated.)

Ordinarily, each forensic report should address only those specific issues and legal questions raised by the court. For example, if the court requests an opinion of competency only, responsibility should not be addressed. Similarly, unless requested, predictions of dangerousness should not be addressed except if they pertain to imminent danger to self or others.

The exact format of the forensic report remains somewhat flexible, but it is encouraged that clinicians use the style and punctuation prescribed by their professional discipline (APA Format). A forensic evaluation is an official court document representing the professional opinion of the licensed clinician performing the evaluation. Consequently, it may become the basis for sworn testimony. Therefore, although proofreading is an appropriate administrative function, it is essential that the evaluating clinician maintain control over the final report's exact wording. To expedite the report reaching the court, it is recommended that the reviewing process be kept to a minimum.

### F. REPORTING REQUIREMENTS

Each of the forensic study sites is required to report on their site's utilization and activities weekly. Responsibility for completing this report in a timely fashion rests with the study site's Chief of Psychology Services. These weekly reports should be sent via SENTRY (Form #354) to the Central Office Psychology Administrator or his/her designee with a copy to the Regional Psychology Administrator.

## 9.2 PSYCHOLOGICAL EVALUATIONS BASED ON STAFF REFERRALS

### A. Referral

Staff members should make a referral for psychological evaluation whenever an inmate displays abnormal behavior or is suspected of being emotionally disturbed. All verbal emergency evaluation requests will be responded to immediately.

Verbal staff referrals may be followed by a written referral which provides useful information, such as the register number of the referred inmate, the nature of the problem, a description of the specific behavior(s) observed, an explanation of what may have led up to the observed behavior, and any specific referral questions.

**B. Assessment**

Psychological assessments conducted in response to staff referrals should be sufficiently complete to answer referral questions. They may include:

(1) Review of mental health screening material (except for new commitments).

(2) Collection and review of additional data from staff observations, individual diagnostic interviews, and previous psychological assessments.

(3) Compilation of individual's mental health history.

(4) Administration of appropriate psychological tests as deemed necessary by the psychologist.

(5) Presentation of findings in a comprehensive, readily understandable report containing relevant test assessment findings, treatment/management plans, and when necessary, appropriate referrals.

The psychologist completing the assessment will forward a copy of the evaluation to the inmate's unit team for inclusion in the inmate's Central File, will maintain one copy in the inmate's PDS record, and will often, where appropriate, also provide verbal feedback regarding the inmate to the staff member making the referral.

Referrals not requiring written responses will result in a verbal answer to the staff member presenting the request and, when appropriate, a short note in the inmate's PDS record describing significant observations, conclusions, and recommendations for programming.

## 9.3 PRESENTENCE EVALUATIONS FOR THE U.S. COURTS

Title 18, U.S. Code, Section 3552 authorizes a sentencing judge to order a period of study of not more than 60 days, if the Court desires more information about an individual who has already been found guilty of an offense prior to imposing a final sentence. While this study is ordinarily conducted in the local community by a qualified consultant, the sentencing judge may refer the case to the Bureau of Prisons if there is a compelling reason to do so or if there are no adequate professional resources available in the local community. At the Court's discretion, this period of study may also be extended for an additional period of not more than 60 days.

The Court Order will ordinarily specify what information the Court needs before determining the sentence to be imposed. Typically, information is requested about the individual's mental and/or physical condition, appropriate treatment recommendations, or what conditions of confinement may be appropriate in the case. If this information is not provided, the Court should be queried to request specific referral questions.

The report format to be used in responding to the Court is presented in Attachment 9-A. In preparing these reports, psychologists should be aware that these reports, once submitted, become the property of the Court and will likely be shared with the defendant, his or her attorney, the prosecuting attorney, and other parties deemed appropriate by the Court.

All 3552 evaluations completed by probationary psychologists, predoctoral interns, postdoctoral residents, and/or BOP consultants are to be co-signed by a licensed member of the Psychology staff.

The psychological evaluation only represents one part of the overall 3552 evaluation process with other disciplines such as Case Management and Health Services making contributions to the final 3552 report sent to the court. In most institutions, the Case Management Coordinator assumes overall responsibility for collecting all study case materials, for coordinating the review of study case materials at the institution level, and for submitting the final 3552 report in a timely fashion to the Regional Office for final review before it is forwarded to the Court. For additional procedural information about 3552 reports, the Program Statement entitled "Study and Observation Report" is referenced.

## 9.4 EVALUATIONS FOR THE PAROLE COMMISSION OR OTHER AGENCIES

Requests for psychological evaluation may, on occasion, come from the U. S. Parole Commission or other agencies. These requests will ordinarily contain clearly stated referral questions and should be addressed in the body of the subsequent report. Typical questions asked by these agencies focus on the inmate's history of mental problems, current mental status, and predictions about future adjustment. Long-term prediction of criminal and/or dangerous behavior should be avoided. However, when responses to questions of this nature are necessary, predictions regarding such acts under specific circumstances should be clearly stated with appropriate disclaimers given.

All reports or summaries written at the request of the Parole Commission or other agencies will be in accordance with the Privacy and Freedom of Information Acts. The format to be used in preparing these reports is presented in Attachment 9-A. All reports prepared by psychology students, interns, residents, or consultants should be co-signed by a licensed psychologist on staff.

## 9.5 COMPETENCY/RESPONSIBILITY EVALUATIONS IN DISCIPLINARY CASES

When an inmate appears emotionally disturbed at any stage of the disciplinary process, a referral should be made to the Chief Psychologist for a determination of the inmate's competence to continue in the disciplinary process (refer to the Bureau's Program Statement on Inmate Discipline and Special Housing Units). Evaluations regarding an inmate's responsibility at the time of the incident may also be requested. Written responses to all referral questions will typically be made by psychology staff within five days of the referral.

## 9.6 EVALUATIONS FOR THE WITNESS SECURITY PROGRAM

Title 18, U.S. Code, Section 3521(c), requires the Attorney General to obtain and evaluate all available information regarding the suitability of any person seeking admission into the Federal Government's Witness Security Program. A psychological evaluation is required as part of the assessment. Bureau of Prisons psychologists have been designated to perform these evaluations.

### A. RESPONSIBILITY FOR MANAGEMENT OF THE PROGRAM

Overall program coordination is the responsibility of the Chief, Psychological Assessment Section (PAS). The Chief, PAS, is responsible for assigning all community candidate evaluations to the PAS staff, or if necessary, to other psychologists within the Bureau of Prisons. When it is necessary for field staff to conduct an evaluation, the Chief, PAS will make such arrangements through the appropriate Regional and Chief Psychologists.

### B. INFORMATION REGARDING EVALUATION PROCEDURES AND FORMAT

When it is necessary to evaluate inmates who are referred for evaluation by either the Inmate Monitoring Branch, the Office of Enforcement Operations, or the Witness Evaluation Section, psychologists should refer for direction to the Program Statement on the "Witness Security Evaluation Program". This Program Statement has been designated "LIMITED OFFICIAL USE ONLY" and should be available from either the Chief Psychologist or the Warden. Information contained in this program statement is intended primarily for use by Bureau Psychologists and should not be reproduced or copies distributed to non-Bureau of Prisons requesters without the prior written approval of the Administrator, Psychology Services Branch, Correctional Programs Division, Central Office.

## 9.7 PSYCHOLOGICAL TESTING

In conducting a psychological assessment, the clinician's preference and the nature of the referral questions should guide the decision as to which specific psychological tests or assessment methods to use. Guidelines for the conduct of psychological testing in the Bureau of Prisons appear below.

### A. TEST ADMINISTRATION

(1) All testing and assessment practices must conform to the APA's Ethical Principles of Psychologists and Code of Conduct, General and Specialty Guidelines for Providers of Psychological Services, and Standards for Educational and Psychological Testing.

(2) Under no circumstances will inmates be used in test administration, interpretation, or clerical handling of test materials.

(3) Group tests may be administered by paraprofessionals, interns, students, or clerical staff. However, in such situations, the Chief Psychologist is responsible for ensuring that adequate training and supervision are provided to guarantee that test administrators can establish proper rapport, give correct instructions, and adequately answer reasonable questions raised by inmates. Additionally, when testing is conducted by staff other than Psychology Services staff, the Chief Psychologist is expected to monitor test administration, procedures, and operations.

### B. CONFIDENTIALITY OF TEST DATA

Test data (defined as scores and/or responses not accompanied by or replaced with interpretive statements) should be kept in a separate psychology file. Such data should not be given to inmates or staff members untrained in the theory and interpretation of psychometric data.

Raw test data should be maintained, like other psychology file information, for a period of 30 years after termination of the inmate's sentence.

### C. INMATE'S RIGHT TO REFUSE PSYCHOLOGICAL TESTING

Inmates have a right to refuse to participate in psychological testing. Such refusals should be documented in the inmate's permanent PDS record.

## 9.8 PSYCHOLOGICAL REPORTS

### A. REPORT CONFIDENTIALITY

Psychologists should be aware that marking "confidential" on any written report will not automatically ensure that its contents will remain undisclosed. The appropriate "test" for exempting a psychological report from disclosure to inmates is the "actual harm test". If the revealed report might result in harm to the inmate, the evaluator, or others, the report should be stamped "FOI EXEMPT" and placed in the FOI Exempt Section of the inmate's Central File.

A summary paragraph such as the one presented below might be used when the full contents of a professional report should not be released to an inmate. This type of summary is ordinarily used for Study and Observation reports, Parole Board reports, and Intake Screening Assessments which contain sensitive material that would be psychologically harmful if revealed to the inmate. Make use of the "actual harm test" for sensitive reports. This paragraph may be adapted to any type of report.

Summary

> A Psychological Evaluation was completed on this date according to standard procedures. The report, which was prepared by a staff psychologist for the _____(Court, Unit Team, Parole Commission, etc.), contains historical information, staff observations, clinical interview and test results, and program/ treatment recommendations. Detailed contents of the report are confidential and restricted. However, salient points presented in this report can be summarized as follows: .....

In most cases it is generally a good practice to verbally review the contents of a psychological report with the inmate to insure that the inmate understands the findings presented in the report. It **is not**, however, a good policy to give an inmate a copy of a completed psychological evaluation for his or her personal records.

### B. REPORT SUPERVISION

The Chief Psychologist, or a designated licensed psychologist, must review and co-sign every report prepared by psychology students, predoctoral interns, postdoctoral residents, or any consultant. The Chief Psychologist is also required to review and co-sign reports written by any new staff psychologist until such time as the Chief Psychologist feels this staff member is fully aware of, and responsible for, following Bureau of Prisons guidelines and procedures.

## 9.9 EVALUATION OF PSYCHOLOGY SERVICES PROGRAMS AND OPERATIONS

### A. ROUTINE PSYCHOLOGY PROGRAM MONITORING

(1) In-house Reviews

This Manual sets forth general guidelines for the development, implementation, and management of all psychology programs in every Bureau of Prisons facility. Each Chief Psychologist is responsible for insuring that all psychology programs within their institution meet this Manual's minimum standards. Chief and Staff Psychologists should meet frequently to discuss on-going program activities and to initiate any corrective actions necessary to remedy difficulties that may exist in meeting policy requirements. Chief Psychologists should also discuss significant problems with the institution's Administrative staff and with the Regional Psychology Administrator.

(2) Local Reports

The Warden of any institution may, for internal purposes, require periodic activity reports from Psychology Services. If such reports are required, copies should be sent through the Warden to the Regional Psychology Administrator.

### B. OPERATIONAL AND PROGRAM REVIEWS

(1) Program Reviews

Psychology Departments at each institution are reviewed by a team of psychologists representing the Bureau's Program Review Division. Review schedules are established by the Central Office Program Review Division. The review team ordinarily consists of a Psychology Examiner from the Program Review Division and a Chief Psychologist from another institution. The Regional Psychologist may also be

present for all or part of the Psychology Department's Program Review. Prior to the review, the Chief Psychologist should assemble information needed for documentation of services delivered. The review team will also obtain needed information through interviews with institution staff at all levels, psychology department personnel, inmates, and from any other data sources they deem appropriate (e.g., PDS).

The program review format, including program components and areas to be reviewed, are published annually in an Operations Memorandum entitled, "Management Review Guidelines for Psychology Services". This document should be consulted regularly for program direction and guidance.

These Psychology Services Program Review Guidelines are created out of the Management Assessment Process which is conducted yearly by the Central Office Psychology Administrator, the Regional Psychologists, and the Program Review Division. The primary goal of the Management Assessment process is to identify the vital functions of Psychology Services in institutions, Regional Offices, and the Central Office, and to target for review those critical areas of greatest concern or risk to the Bureau.

(2) Operational Reviews

In addition to formal Program Reviews, each institution is also expected to conduct an annual internal Operational Review. The results of the internal Operational Review should be forwarded to and maintained by the Regional Psychology Administrator.

For additional information about the Program Review Division or the Program/Operational Review process, the Bureau's Program Statement entitled "Management Control and Program Review Manual" is referenced.

# COURT AND/OR OTHER OUTSIDE AGENCY EVALUATION FORMAT

BOP Name of Facility
Location of Facility

## Psychological Evaluation

Name: _____ Register Number: _____ Date: _____

Date of Birth:

Date of Evaluation:

Tests Administered:
1.
2.
3.
4.
5.

Reason for Referral:
Identify name, age, and race/ethnic group. Identify source of referral, e.g., U.S. District Court in the Southern District of New York. For a court evaluation, identify the length of evaluation the sentencing code, and offense, if applicable. List referral questions, or indicate no referral questions.

Findings (May include the following):

Background Information: Write a concise history of the individual and clearly identify any contact with Mental Health professionals and pertinent history information. Indicate whether or not the obtained interview history agrees with the Pre-Sentence Investigation Report and interview information, write a very short history and state that the historical material is in the Pre-Sentence Investigation Report.

Behavioral Observations: Comment upon behavior during the clinical interview and testing sessions. List verified staff observations of the inmate outside of the evaluation sessions, both positive and negative.

Mental Status: Identify the presence or absence of significant psychiatric symptomatology or pathology. Areas should include orientation, presence/absence of hallucinatory activity, delusions, affect, judgment, internal control, etc.

Organicity and Intellectual Functioning: Identify the level of intelligence. Professional Judgment is to be exercised when revealing specific IQ or general intelligence level. Comment upon the presence or absence of brain damage, motor impairment, organic disorder, and other related physical disorders, and whether treatment could be beneficial or corrective.

Personality: Identify personality strengths/weaknesses within a context of personality/behavioral dynamics. This may be the longest section, and the professional has the greatest latitude for description of the client. If specific dynamics are identified, behavioral or historical correlates as examples convey a clearer picture to the non-professional reader. Be careful of excessive or misinterpreted jargon.

Response to Referral Questions: This section is to be used only if specific questions have been asked. If there are no questions, then omit this section and place findings in the Conclusion section.

Diagnosis: This section is not to be used unless specifically requested. If a diagnosis is requested, use DSM-III-R.

Conclusion: Use one line to identify the case and referral issues. Describe in clear and unambiguous terms the general findings and abbreviated specific results. Treatment recommendations, if any, are to be as specific as possible. There should be no treatment recommendations for competency evaluations unless specifically requested.

_____
Psychologist's Name
Title